# Medical Review Panel Report

## A Review of the Administrative, Policy, and Procedural Functions of the MRP Process, with Identification of Issues and Recommendations

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Presented to the Board of Governors
of the Workers' Compensation Board of B.C.
August 17th 1992

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# THE MEDICAL REVIEW PANEL REPORT

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Presented to the Board of Governors of the Workers' Compensation Board
August 17, 1992

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The decisions and findings flowing from medical questions are only a part of the complex decision making involved in a claim for compensation. Often, however, the medical questions on a claim are the most important and difficult questions to be answered.

The Workers Compensation Act recognizes the significance of medical issues in the adjudication process by providing for a right of appeal to a panel of three physicians independent of the Workers' Compensation Board. This is a deliberate exception to the exclusive authority of the Board to determine all questions of fact and law relating to compensation matters.

An external Medical Review Panel is an inviting recourse when a party is dissatisfied with a decision of the Board or a finding of the Review Board. The Panel may disagree with the treating physician or the opinion of the Board doctor and the Panel's decision is final, conclusive and binding.

The Act intends that the Medical Review Panel process be openly administered and that the Panel members receive the support, education, and training necessary to be competent in their roles. It intends that the Board be as respectful of the authority and competence of Medical Review Panels as the Courts are asked to be in regard to the Board.

In September 1991, the Governors of the Workers' Compensation Board commenced an examination of the Medical Review Panel process. Dr. Leonard C. Jenkins, an independent physician with recognized qualifications, was retained to conduct an independent study. The results of his study, as set out in this report, were presented to the Governors at their August 17, 1992, meeting.

Over the coming months, the Governors will be considering Dr. Jenkins' recommendations for changes in policy and amendments to the Act. In doing so, the Governors will consult with persons interested in the Medical Review Panel process.

At the same time, Dr. Jenkins will be working with the Medical Review Panel Chairmen and the Medical Review Panel Department to implement his administrative recommendations. Included will be recommendations for reducing delays and increasing efficiency of the Medical Review Panel process, improving the education of the Chairmen, Specialist Members and Medical Review Panel Department staff, and instituting a quality assurance program.

I am confident that Dr. Jenkins' report will be a valuable resource for all participants in the workers' compensation system as we search for ways to improve the Medical Review Panel process.

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# SECTION 1

# MRP REPORT BACKGROUND

## 1.1 FOREWORD

This *Medical Review Panel Report, a Review of the Administrative, Policy and Procedural Function of the Medical Review Panel (MRP) Process, with Identification of Issues and Recommendations*, was undertaken at the request of James E. Dorsey, Chairman, Board of Governors, Workers' Compensation Board of British Columbia (WCB). However, I have been appointed as an independent consulting physician, as the Registrar, Medical Review Panels with a mandate of reviewing the MRP process with particular reference to identification of Issues and making recommendations to improve the system. Although working on a part-time, one-year basis, I have had complete freedom and independence from the WCB in my approach and ability to pursue documents, to interview both in-house and community individuals, groups and representatives. In each instance I have had outstanding reception and cooperation, and enjoyed establishing a good working rapport whenever it was required.

I have indicated in the Report that some Recommendations could be implemented easily and quickly, while others, if accepted by the Governors, would require further negotiation and discussion. I have also indicated that a limited number would require amendments to the Workers Compensation Act.

I have not prioritized the Issues or Recommendations, as I believe that this is the prerogative of the Governors. At an appropriate time, I would be prepared to give my views on this. Nor have I included an analysis of the input or any discussion of the pros and cons of the interviewees' content, as I have endeavored to have their comments digested and reflected, wherever possible, in my statements on the Issues and Recommendations, as they stand in the Report.

I have received excellent consultative advice from Heather Greene, Legal Advisor; Terry Bogyo, Executive Assistant to the Chairman; and Judy Olson, Manager, MRP Department; and strong expert secretarial services from Wilma Chapman, Administrative Assistant to the Chairman, and Secretaries, Sylvia te Boekhorst and Helen Hii.

In the end, the Report is my doing and I accept the responsibility that goes with it for any errors of fact or interpretation that might remain. It remains a report by an independent physician.

L.C.J.
August, 1992

# 1.2 EXECUTIVE SUMMARY

## INTRODUCTION

The Medical Review Panel process evolved[1-7] out of concern for achieving fair, cost effective, and consistent resolution of difficult complex medical issues involved in occupational injury/disease claims. (Appendices 5-8)

It is intended that this report will serve as

- A public document for information and education on the current administrative, policy and procedural function of the Medical Review Panel process; and

- An identifier of Issues within the process that have led to Recommendations aimed at facilitating and improving the process.

The Report's findings are based on a review of the Medical Review Panels' (MRP) processes. Where possible, a statistical analysis has been undertaken, a literature search on related systems has been done [8,18-23], and interviews have been conducted with all Chairmen of the MRP, selected Specialist Members, and 52 representative groups and individuals involved in workers' and employers' interests in the community.

The MRP process is a unique and significant process in the dispute resolution systems in the Workers' Compensation Board of British Columbia. It is the final decision-making process on matters pertaining to the medical questions on the appeal. The decision of the MRP is binding on the Board.

There is an exquisite balance in the relationship of the Medical Review Panel process to the Board. On the one hand, there is a need for independence from the Board. On the other hand, the compilation of data upon which an MRP can make a judgemental decision is dependent upon the Board's resources and personnel. There is a sensitive balance in that relationship which is important to preserve and maintain.

To further the independence of the MRP process and to eliminate any arguments regarding conflicts of interest within the Appeal Division, the Board of Governors made a decision in October 1991 to remove the Medical Review Panel administration from the Appeal Division and made it a separate entity as a Department with its own geographically separate unit. The position of Registrar, Medical Review Panels was created as well as the Managerial Position within the Department. The MRP Department reports to and is responsible to the Chairman of the Board of Governors.

# THE MRP DEPARTMENT

A schematic organization of the Department is found in Figure 1 and the composition of the MRP Department in Table 1. The Medical Review Panel Department administers the Medical Review Panel process.

### Position Descriptions and Mandates of the Registrar Position

A position description of the Registrar is outlined in Appendix 1. The curriculum vitae of the current Registrar is outlined in Appendix 2. There are two basic mandates of the Registrar position. The first is to oversee the administrative side of the Medical Review Panel process and the second is to identify issues in that process and make recommendations in order to facilitate and improve the Medical Review Panel process.

### Manager Position

A managerial position was established when the MRP system was developed into a separate department from the Appeal Division. The Senior Medical Appeals Officer was promoted to this position. The Senior Medical Appeals Officer position has not been replaced in person nor in budget allotment. The managerial position is essential to the administrative overview of the departmental functional phases and personnel. In addition, the position is responsible for the development and operation of the budget, departmental statistics, planning, recruitment and day-to-day operation of the department in general.

There is a close administrative inter-relationship between the Manager and Registrar of the Medical Review Panel.

# THE MEDICAL REVIEW PANEL PROCESS OVERVIEW

A descriptive schematic flowchart of the time/volume flows involved in the Medical Review Panel process are summarized in Figure 3. There are nine stages within the Medical Review Panel administrative, policy, procedural and functional processes. These are:

### Initiating a Medical Review Panel Appeal

The source of applications, the access routes to the Medical Review Panel Appeal, and the applications profile are summarized in Tables 2-4 and Figures 2-4.

### The Physician's Enabling Certificate

The Physician's Enabling Certificate establishes a bona fide medical dispute. (See Appendix 9, which provides information for physicians completing MRP Enabling Certificates.)

## The Development of the Statement of Foundational Non-medical Facts and Issues by the Medical Appeals Officer

Within this process there are nine issues normally developed and presented to the Panel for decision. Other issues may be added depending on the circumstances of the case.

Issue 1 - Condition of the Appellant
Issue 2 - The Existence of a Disability
Issue 3 - The Nature and the Extent of the Disability
Issue 4, 5 and 6 - Related to the Cause
Issue 7 - Temporary Disability
Issue 8 - Pre-existing Disability or Condition
Issue 9 - Permanent Disability

## The Designation of Specialty

The Registrar assigns a Specialty on the basis of a review of the complete file of the medical factors and the Statement of Foundational Non-Medical Facts and Issues. Tables 8.1 and 8.2 summarize the frequency of the specialties used in the Medical Review Panel process during 1991 and 1992 (from January 1 until June 30).

## The Formation of the Panel: Chairman and Specialists

A Chairman is scheduled for a given panel on the basis of availability by the Panel Scheduling Clerk of the department. Table 9 lists the Medical Review Panel Chairmen and their date of appointment. The choice of one Specialist Member each is made by the employer and worker on the basis of a list of Specialist Members for the given specialty that is circulated to the employer and the worker. The specialties available for MRP Panels are summarized in Table 7. The lists of Specialist Members are found in Appendix 4. Both the worker and employer are asked to make their top three choices in descending order of preference. Every effort is made to respond to the first choice in each instance. There are a number of disqualifying factors for Specialists and Chairman on a given MRP. These factors are summarized in Table 10. The Medical Appeals Officers oversee this, in consultation with the Registrar.

## The Conduct of the MRP[18]

In conducting a Medical Review Panel examination, Section 61 (5) of the Act provides, "the Panel shall determine its own procedure." This means that it is entirely up to the Medical Review Panel to determine how it will conduct its examination of the worker in consideration of the issues. The Board has no authority to issue instructions to Medical Review Panels about the procedure it follows. (See also *Rehabilitation Services & Claims Manual* #103.44 "Procedure of the Panel" in Appendix 7 and the Workers Compensation Act Appendix 5.)

Every effort is made by the Chairman and Specialists Members to put the worker at ease during the examination. Emphasis is placed on the fact, during introductory remarks, that the Panel is an independent group of non-biased, non-political physicians trying to objectively examine the facts.

Panels involve the taking of a history and the complete physical examination of the worker. Upon the completion of the examination, the three physicians then discuss their findings. A Certificate is prepared by the Chairman. The Chairman also drafts a Narrative Report and distributes these to the Specialists for their approval. Only two of the three Panel members need agree, but each member of the Panel signs the Certificate and Narrative Report. A dissent opinion may be written. The Certificate, in essence, contains the answers to the questions the Panel was charged with.

### The Certificate

Within a reasonable period of time after the examination of the worker, the Panel is required to certify the results of the examination, for the Board, as set out in Section 61 of the Act. (Appendix 5)

The Certificate from the Medical Review Panel is conclusive as to the medical matters certified. The Board is bound by it. It is not open to question or review in any court and no proceedings by or before the Panel shall be restrained by injunction, prohibition or other process or proceeding in any court or be removable by certiorari or otherwise in any court. (Section 65 of the Act)

### The Narrative Report

The Narrative Report is compiled and prepared by the Chairman of the Medical Review Panel. It accompanies the Medical Review Panel Certificate. It is a detailed document summarizing and focusing on the data provided by the Board with regard to the file information, the detailed findings of the history-taking and physical examination. It will sometimes contain sensitive personal medical information recommending a form of action beneficial to the worker's condition.

### The Medical Review Panel Certificate Implementation

The Certificate of the MRP is returned to the Medical Appeals Officer of the MRP Department, documented, then referred on to the Compensation Services Division, which has been responsible for reviewing certificates directly since June 3, 1991. It is reviewed at this time by the Claims Adjudicator in consultation with his/her manager to ensure that the Panel has remained within its jurisdiction and that the intent is clear. If the Certificate is within the Panel's jurisdiction and the intent is clear, the issue is resolved decisively.

If there is a need for clarification, the Certificate will be sent to a specialized group reporting to the Vice-President in the Compensation Services Division. In consultation with the Registrar of the Medical Review Panels, the Certificate is reviewed. The procedure for resolving disputes in implementation is set out in Appendix 11.

Other issues addressed in the Medical Review Panel process overview are as follows:

### The Appointment of Chairmen and Specialist Members of the MRP

The appointment of Chairmen is by Order-in-Council by the Lieutenant-Governor-in-Council. Appointment is without term. There is no established termination process nor guidelines available for this procedure.

In general terms, the Chairmen are seen by their peers as physicians or surgeons who are broadly based in their clinical knowledge, have excellent judgement, are widely experienced clinically and able to express decisions with clarity. Table 9 summarizes the current Medical Review Panel Chairmen and their times of appointment.

Appendix 3 summarizes the curriculum vitae of the current Chairmen.

The Specialist Members are appointed by a joint medical committee of the College of Physicians and Surgeons of British Columbia, and the BCMA. The composition of this committee is outlined in Table 6. Appendix 4 depicts the current Specialist Members available to the Medical Review Panel process.

### Education/Training of Chairmen, Specialist Members, Medical Review Panel Department Staff

There are current orientation guidelines for new Specialist Members. (See Appendices 10.1, 10.2.)

An initial Chairmen's Education Day was held on May 29, 1992. The Brochure for this program is outlined in Appendix 14, and Appendix 15 depicts a summary of the Program Appraisal Forms.

### Medical Review Panel Quality Assurance

There is currently no formal quality monitoring process for the performance of Chairmen or Specialist Members of MRP Panels, nor for the members of the MRP Departmental Staff.

The Registrar has reviewed some 300 Medical Review Panel Certificates during the past year, including all the new MRP Certificates arising since September 1, 1991, as to quality of clarity, format and time frame of responding.

### Position of Registrar, Medical Review Panels

This appointment was made on September 1, 1991 for a one-year period. The description of the position is in Appendix 1.

The Registrar, Medical Review Panels, can play a key pivotal role in interrelating the MRP Department with internal WCB interactions. There is also a significant role for interplay with the community of workers, employers and their representatives. The Registrar has a major role interrelating with the Chairmen of the MRP and facilitating their activity and those of the Specialist Members of the Panel. In essence, the Registrar can form the role of a key gatekeeper with respect to the problems arising from implementation of the Certificate and its development.

### Interaction with Groups and Representatives

Although the Medical Review Panel process is an independent system, it must also be seen to be independent, free of bias and political influence and fair and abiding by the principles of natural justice.[35] However, the process does not function in isolation. There is interaction with significant groups, individuals, and representatives. The feedback and exchange of views are helpful to the process and its final outcome and performance, although, in some instances, they delay the decision or the implementation of the MRP Certificate and will increase the cost associated with the MRP function. These interactions are addressed in Sections 4.1 and 4.2 – Issues and Recommendations – and in Section 2.7 of the Report.

### Amendments to the Act

As a result of the issues raised in the Medical Review Panel process, a number of recommendations have arisen that require considerations for amendments to the Act that are required to Sections 58 - 66. These are summarized in Section 4.3, Proposed Amendments to the Act.

## PERFORMANCE/OUTCOMES OF THE MEDICAL REVIEW PANEL

Data depicting performance and outcomes of the Medical Review Panels are summarized in Figures 4 and 5 and Tables 2-5, 8.1, 8.2, 11-15, and Appendices 8, 12 and 13. A review of the performance and outcomes is presented from the following five headings:[7]

### Frequency of Use

Access routes to the MRP process are depicted in Figure 2. Table 2 clearly indicates that a majority of applications to the MRP are currently arising from the Appeal Division decisions and referrals (55%). Other source patterns for new MRP Appeals are from decisions by Board officers (22%), findings by Review Board (14%) and by Bill 15 (Decision 3) (10%). (Appendix 6)

This increase in MRP appeals is a reflection of a time of transition in the Appeal Division, coping admirably with a reduction of the backlog.

However a continuing increase in appeals could be sustained by the potential activation of backlog reductions arising from the Review Board.

Applications have continued to increase over the past five years (Tables 3, 4, and Figure 4), as have the numbers awaiting consideration. Five hundred applications were received during 1991. This represents a 40% increase over 1990 (Table 3). Four hundred and eighty-five applications are awaiting consideration and being processed as of June 30, 1992.

The specialties that were used in Medical Review Panels in 1991 and January to June 1992 are summarized in Tables 8.1 and 8.2. Orthopaedic surgery is by far the most commonly used specialty (73% of the Panels).

## Satisfaction

The average number of days for the completion of Medical Review Panels has generally decreased, although not consistently, over the past seven years (Table 5). In 1985 the average number of months was 29, while in 1990 it was 7.9 months. During 1991 it was 400 days or 13.1 months (Figure 3) for completion of MRP appeals. The time from the date of application to the implementation of the MRP Certificate has improved.

However, the Issues have identified that further improvements in efficiency of the process are possible. Twenty-seven of the 131 Recommendations in the report deal with the question of reducing delays.

Medical Review Panel Certificates have been consistent on decisions and outcomes of appeals over the past five years (Figure 5 and Tables 12 and 13): 39% of Certificates uphold (confirm) the Board's decision; 51% disagree and 10% partially disagree (uphold). The percentage of Chairmen's Panels that did not confirm Board decisions varied between a low of 30% and a high of 76.92%, over the past five years (Table 14).

With respect to Table 14, the variations in Panel decisions related to the Chairmen might not be as significant as first seen. It is important to remember that the Medical Review Panel as a whole makes the decision, not the Chairman alone. The percentage of Panels that did not confirm Board decisions is therefore not truly a reflection of any given Chairman. Also, the percentages are somewhat skewed by the numbers of panels involved. The Panels under 15 appear at the lower and upper extremes of the percentages.

From the appellant's perspective, there is probably more satisfaction gained from the review of the Certificate than that of the employer or the Board. An important factor for all concerned is that the medical issue is finalized by the MRP process.

No interviewees felt that the MRP process should be discontinued, although I have identified 158 issues within the system.

## Time Phases Through the MRP Process: Possible Delay Factors

Figure 3 depicts the MRP process with respect to volume and time flow patterns during 1991. Sixty percent of the overall time is taken from the time of reception of an application until the MRP examination. Forty percent of the overall time is from the time of the examination to the time of the MRP implementation. Since the Chairmen's Education Day of May 29, 1992, following a discussion of Panel Chairmen performance, on average they took 40 days to return Certificates to the Board from the time of their Panel examination. This time now has fallen to an average of 21 days as of June 30, 1992.

All the time frames indicated in Figure 3 are being analyzed with regard to efficiency. These issues have been addressed in the Recommendations.

## Costs

Table 15 summarizes the 1991 estimated (projected) costs per MRP. On the basis of the MRP Department operating budget alone, this was $2,883 per Panel; on the basis of medical aid – that is, the Chairmen and Specialist Members on the Panel alone – the cost is $2,272 per Panel; on the basis of 500 applications received, the cost is $2,093 per Panel; on the basis of MRP implementations (203), the cost is $5,145 per Panel.

## Features that Contribute to the Success and Failure of the MRP Process

The MRP process is considered a success in B.C. by all parties interviewed. The fact that it is not immune to criticism is apparent from the number of issues that I have been able to identify (158) (see Section 4.1).

In order to maintain the system as a success and not let it lose its credibility, it is imperative that vigilance and attention be given to the following areas that would result in an even better process.

- Reduce or eliminate causes of delay.
- Maintain and reinforce the binding nature of the decision.
- Continue to enhance credibility of the Panelists and Chairmen.
- Reduce the number of appeals requiring clarification, interpretation reconvening, or those deemed null and void.

These factors are addressed in the sections on Issues and Recommendations in the Report (Sections 4.1 and 4.2 respectively).

## THE ISSUES

There are 158 Issues raised in this report. The background information for the Issues is presented within the organizational function and flow of the Medical Review Panel process as outlined in the overview. The actual issues are presented in Section 4.1 of the report.

These issues were developed as a result of my viewing Workers' Compensation Board documents and having a widespread search of the literature, publications and information received from my interviews. (See Appendix 12 and 13.) This document of issues was circulated to those interviewees and others (see Appendix 12) and a response and comment to these issues were requested of the Chairmen, Medical Review Panels and the 52 other groups, individuals and representatives who received the issues. There was a 65% return rate with many helpful comments and suggestions.

The issues identified within the Medical Review Panel process, in the form of questions, are discussed under Section 4.1 of the Report.

## THE RECOMMENDATIONS

The recommendations basically arise from the answers to the questions that were posed in the Issues. These are presented in Section 4.2 of the Report.

There are 131 recommendations presented for consideration.

A significant number of the recommendations can be implemented easily and relatively quickly. Some, if accepted, will require further discussion and negotiation. A limited number would require amendments to the Act.

# 1.3 INTRODUCTION

## THE MEDICAL REVIEW PANEL (MRP) PROCESS

Occupational injury and disease claims are difficult and expensive for workers' compensation systems to resolve. They also raise complex medical issues - diagnosis, causation, the extent of current and future disability, and apportionment between work-related and non-work-related causes. The resolution of these cases in a prompt, predictable and fair manner requires the evaluation of specialized technical evidence by the parties and by the adjudicators. Many question the ability of lay decision-makers to accurately evaluate conflicting medical opinions brought before them by parties having differing interests in order to produce fair, consistent decisions.

The Medical Review Panel process evolved out of concern for achieving fair, cost-effective, and consistent resolution of these difficult issues and occupational injury/disease claims[1-3,6,7] (Appendices 5-7.). Of particular significance and historical interest in the founding and guiding principles of the MRP process are the reports by Sloan[1] and Tysoe[2].

Although the notion of a medical Panel – a select group of specialists who examine the appellant (worker) and render an opinion on complex medical issues – has substantial appeal on its surface, the public and even the community of physicians know very little about how the Medical Review Panel process operates or that shortfall issues might exist within the process.

It is intended, then, that this report will eventually serve as

- A public document for information and education on the current administrative, policy and procedural functions of the Medical Review Panel process; and
- An identifier of issues within the process that have led to recommendations aimed hopefully at facilitating and improving the process.

The report's findings are based on a review of the process [1 - 7], where possible a statistical analysis, literature research on related systems[8, 18-23], interviews with all Chairmen of the Medical Review Panels of B.C., selected specialists, and 52 representative groups and individuals involved with worker and employer interests, in the community and within the Workers' Compensation Board (WCB). (Appendix 13.)

The MRP process is a unique and significant process in the dispute resolution mechanisms of the workers' compensation system in British Columbia. It is the final decision-making process on matters pertaining to the medical questions on a worker's claim. The decision of the MRP is binding on the Board. Only two other provinces in Canada – Saskatchewan and Manitoba – utilize the Medical Review Panel process in solving medical disputes.[6]

Related medical appeal tribunals are in practice in a limited number of states in the USA[7], and throughout the Commonwealth[26], including Britain[18]. These tribunals are fashioned basically on the British system of medical appeal tribunal principles. They are, however, advisory only on matters pertaining to medical issues.

There is an exquisite balance in the relationship of the Medical Review Panel process to the Board. On the one hand, there is a need for independence from the Board. On the other hand, the compilation of much of the data upon which an MRP can make a judgemental decision is dependent upon the Board's resources and personnel. There is a sensitivity of balance in that relationship which is important to preserve and maintain.

To further the independence of the process and to reduce any seemingly possible conflict of interest within the Appeal Division, the Board of Governors made a decision in October of 1991 to remove the Medical Review Panel section from the Appeal Division and made the MRP a separate entity as a department with its own geographically separate unit. The position of Registrar, Medical Review Panels was created, as was a managerial position within the Department. The MRP Department reports to and is responsible to the Chairman of the Board of Governors.[4,5]

The organizational chart of the MRP Department is depicted in Figure 1. The composition of the MRP Department is outlined in Table 1.

## THE SCOPE OF THE REVIEW

The review encompasses the following processes within the MRP system and provides an overview of the administrative functional aspects of the MRP processes through these nine administrative stages:

1. Initiating a Medical Review Panel
2. The Physician's Enabling Certificate: Establishing a Bona Fide Medical Dispute
3. Statement of Foundational Non-Medical Facts and Issues
4. Designation of Specialty
5. The Scheduling and Formation of the Panel with Chairmen and Specialists
6. The Conduct of the MRP
7. The MRP Certificate
8. The Narrative Report
9. MRP Certificate Implementation.

In addition, the following areas and activities were also reviewed:

1. The Appointment Process of Chairmen
2. The Appointment Process of Specialist Members
3. The Education/Training Aspects of Chairmen, Specialists, MRP Departmental Staff
4. The Conduct of the MRP
5. MRP Quality Assurance
6. The Role of the Registrar, Medical Review Panels
7. Medical Review Panel administrative matters
8. The interplay with groups and representatives within the WCB and the Community
9. Amendments to the Act required to improve the process.

## METHODOLOGY

The following approaches were undertaken:

### Documents Reviewed

A significant number of documents related to the process within the WCB were reviewed initially. This was supplemented with liberal use of the various library collections to identify any material related to the MRP Panels[1-35]. A striking finding was that the amount of published information on the MRP was extremely limited and scarce.

### Research of Literature

A wider search of the literature[1-35] related to the MRP process was undertaken with the kind assistance of Sam Isaacs, WCB Disability Awards Department, Compensation Services Division. Again, specific published data relating particularly to MRP processes was, indeed, scarce. However, background information and related processes were helpful. The results of the document review and literature search are reflected in the list of References and the Appendices.

### Sessions/Interviews for Internal Orientation and Identification of Issues

This process involved meetings with key individuals in most divisions and appropriate sections within the WCB. Specific areas are reflected in Appendices 12 and 13 under "Interviewees", and in Sections 4.1 and 4.2, Issues and Recommendations.

### Sessions/Interviews for External Orientation and Identification of Issues

A broad approach to community interest and influence of various individual groups and representatives was undertaken. Fifty-two such interviews took place, and these are reflected in Appendix 13 and in Section 4.1 and 4.2 of the Issues and Recommendations.

### Meetings

Involved meetings with the MRP Chairmen as individuals and as a group on the Chairmen's Education Day, and meetings with selected Specialist Members provided a special focus on the issues associated with the MRP process.

### Statistical Analysis

Wherever possible, a statistical analysis of the performance and outcome of the MRP process was undertaken. Because the MRP Department did not exist, as such, until October 1991, some of the statistical analysis is limited. Some data as it pertains to the performance of the MRP process, however, does reflect on the past five years. (Figures 3-5; Tables 3-5, 8.1, 8.2, 9-15 and Appendix 15)

The descriptive review of the MRP process reflects on the current status, as it exists from October 1991 until time of the report August 1992.

## ORGANIZATION OF THE REPORT

The Report initially reviews the current status of the MRP process with respect to its administrative, policy and procedural functions, its relationship with groups and representatives within the WCB and the community at large.

It reviews the current, immediate past, and past five years' performance and outcomes of MRP activities. As a result of the review of all this information, along with the interviews that took place as described in the methodology, a basis for the identification of issues was made. The issues were then organized within the framework outline of the functional processes of the Medical Review Panel and its associated activities, as outlined in the scope of the review. A number of questions were raised as issues, 158 in total, including proposed amendments of the Act. The answers to the questions raised in these issues became the basis of the recommendations. There are 131 recommendations identified within the process.

# SECTION 2

# AN OVERVIEW OF THE CURRENT MEDICAL REVIEW PANEL (MRP) PROCESS

## 2.1 ADMINISTRATIVE, POLICY AND PROCEDURAL FUNCTIONS

### INITIATING A MEDICAL REVIEW PANEL APPEAL

Figure 2 summarizes the access routes to the MRP process. In a dispute over a medical issue, a worker or an employer may appeal a WCB decision to a Medical Review Panel directly or through a progression of the WCB, Review Board and Appeal Division. Prior to July 4, 1988, an appeal to an MRP could be made after a Review Board decision – but from that date until June 28, 1991, appeals to an MRP were allowed only after an adjudicator decision or subsequent to a decision by the Commissioners. The policy has now returned to the original arrangement (see Bill 15 – Appendix 6). Appellants must file their request for an MRP review within 90 days of the WCB decision. Most appellants do not apply directly to the Medical Review Panel process. They usually use the route of the Review Board and Appeal Division appeal mechanism first. This may take several years.

Table 2 depicts a summation of the statistical data indicating the source patterns for new MRP applications from these routes. It is significant that more than 55% of the applications for appeals arise from the activity of the Appeal Division, as can be seen from Table 2 and Figure 2. Of this 55%, 48.6% arise from Appeal Division decisions, and 6.6% from referral. The second-largest source is from Board Officers at 21.2%, third, the Review Board at 13.6% and fourth, Bill 15 (Decision 3) at 10%. (See Appendix 6.)

Tables 3-5 and Figures 3 and 4 depict further statistical analysis of activity associated with applications for appeal. These will be discussed in more detail within Section 3 – MRP Performance and Outcomes.

### THE PHYSICIAN'S ENABLING CERTIFICATE ESTABLISHING A BONA FIDE MEDICAL DISPUTE

In order to be allowed to appeal a decision to an MRP there must be a bona fide medical dispute. The worker/employer must obtain a certificate from his or her physician stating that there is a bona fide medical dispute "with sufficient particulars to define the question in issue".

According to Section 1 of the Workers Compensation Act (Appendix 5), a "physician" means a person registered under the Medical Practitioners Act, as contrasted with a "qualified practitioner" which means a person registered under the Chiropractors Act, Dentists Act, Naturopaths Act or the Podiatrists Act. This means that only a B.C. physician may raise an Enabling Certificate establishing a Bona Fide Medical Dispute.

Definition of terms is interesting here in that "bona fide" refers to "in good faith, honestly without fraud, collusion or participation in wrongdoing". "Medical" refers to "of or relating to the science of medicine in general" and "dispute" refers to "a disagreement, a debate or argument".[30]

A bona fide medical dispute is a real disagreement on a medical question. In order for a physician's certificate to be accepted as defining a bona fide medical dispute, a physician must set out exactly in what respect he or she disagrees with the medical decision in dispute (see Appendix 9, Example Form, Current Enabling Certificate).

With reference to "sufficient particulars to define the question in issue" as background, it should be noted that in order for a Certificate to be accepted it must explain how and why the physician disagrees with the medical decision in dispute, with medical reasons to support the opinion. The opinion must be sufficiently detailed to define the medical issue in dispute. This is referenced in Section 58 (3) and 58 (4) in Appendix 6 on the Act, and Appendix 7 on the *Rehabilitation Services & Claims Manual* of the Workers' Compensation Board of British Columbia, Section #103.12 - Certificate of a Bona Fide Medical Dispute. (Also see Appendix 9, Information for Physicians Completing Medical Review Panel Certificates.)

In essence, the whole reason for a Medical Review Panel examination is to resolve a medical disagreement between the appellant's physician and the Board Appeal Division or the Review Board. The question at issue is strictly medical in nature.

The identification of the bona fide medical dispute is left to the appellant's physician (usually the worker's attending physician) who submits the Enabling Certificate Form (see Appendices 9 and 9.1), attesting to the presence of a dispute, to accompany the request for the MRP. The Certificate, in turn, is evaluated by a Medical Appeals Officer of the Medical Review Panel Department. It is either accepted or the worker/employer is given further opportunity to procure a satisfactory Certificate. If the Medical Appeals Officer finds that there is no bona fide medical dispute, that determination may be appealed to the Review Board. Figure 3 figuratively depicts the Medical Review Panel process and the initiation phase of applications in this overall process. Table 4 summarizes applications awaiting consideration and being processed. This is further discussed under Section 3 – Medical Review Panel Performance and Outcomes.

## THE STATEMENT OF FOUNDATIONAL NON-MEDICAL FACTS AND ISSUES

Where an MRP is warranted, a summary of the non-medical facts is prepared and sent with all salient, pertinent medical reports ('split file') to a Chairman of an MRP. A set of nine or 10 questions is given to the MRP with instructions that the Panel limit its response to those issues only. The Panel is absolutely bound by the WCB's non-medical findings in the case, which raises the question of the MRP's jurisdiction.

The term "jurisdiction" refers to "the power of a Court or Judge to entertain an action, petition or other proceedings."[30] Jurisdiction then refers to the genesis and ambit of a body's decision-making authority. The jurisdiction of a Medical Review Panel is set out in Section 61(1) of the Workers Compensation Act (Appendices 6 and 7). According to this section, a Medical Review Panel has the jurisdiction or authority to make decisions with respect to:

- the condition of the worker;
- the existence or non-existence of a disability;
- if there is a disability, its nature and extent, but not stated in terms of percentage of disability of the whole body;
- if there is a disability, its cause and, if there is more than one cause, how much of the disability is related to one cause and how much to another;
- if the worker, though no longer disabled, claims that he had a longer period of disability, total or partial, than that allowed him by the Board, then and in that event, whether he was in fact disabled as a result of the happening or incident which caused the disability, for a longer period than that allowed him by the Board, and if so, for what longer period he was disabled and the nature and extent of his disability during the period beyond that allowed him by the Board, but not stated in terms of percentage of disability of the whole body.

The Medical Review Panel's jurisdiction is confined to medical issues. The Medical Review Panel has no jurisdiction over questions of lawful entitlement to compensation. The Board has the jurisdiction to determine entitlement to further compensation on the basis of the medical decisions contained in the Medical Review Panel's Certificate.

Background information to the term "issues" is useful. In the list of Issues attached to the Statement of Foundational Non-medical Facts, the Board paraphrases the Medical Review Panel's jurisdiction set out in Section 61(1). Section 61(3) gives the Board the authority to submit questions to the Panel relating to matters enumerated in Section 61 (1) and the Certificate of the Panel is to include an answer to these questions.

The Board uses the same basic list of issues in every Medical Review Panel examination, modifying each question in accordance with the facts of the particular claim under appeal. A parallel generally exists between the issues and the jurisdiction of the Medical Review Panel as set out in Section 61(1):

Issue #1 Condition:
Section 61(1)(a)

"Condition is the state of being or fitness of a person or thing."[30]

In Issue #1, the Medical Review Panel is asked to certify as to the worker's condition or general fitness. The response to this issue is generally poor, fair, good, or excellent. This information is not used by the Board to make any particular determination of further entitlement.

## Issue #2 The Existence of a Disability:
Section 61(1)(b)

Disability is variously defined as:[30]

- a physical incapacity either congenital or caused by injury, disease, etc.;
- a lack of some asset, quality or attribute that prevents one's doing something;
- a lack of ability to function normally, physically or mentally; incapacity;
- anything that causes disability.

As defined by the Federal Government:[9]

"Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last or has lasted for a continuous period of not less than 12 months."

In Issue #2, the Medical Review Panel is asked to certify as to whether the worker has a disability at the time of the Medical Review Panel's examination or historically.

#103.52 of the *Rehabilitation Services & Claims Manual* (Appendix 7) discusses the meaning of the word disability in this context. It provides that the word "disability" is a concept, with medical, economic and legal aspects. It divides the question into two subsections:

1. does the patient have any after-effects from the compensable injury or disease;
2. should those after-effects be classified as a disability for compensation purposes?

The *Manual* suggests that the first question is a medical one in which the conclusion of the Medical Review Panel is decisive. It suggests that the second is a question of law and policy for the Board to determine. The *Manual* provides:

"Thus, if it appears to a Medical Review Panel that the patient has something, but there is doubt about whether it should be classified as a "disability", the Panel should simply certify what it has concluded the patient has, together with the functional significance of whatever it is. The Board can then determine whether it should be classified as "a disability"."

The Medical Review Panel's jurisdiction in determining disability is confined to medical findings of disability. It cannot certify that a worker is entitled to further disability benefits.

Issue #3 The Nature and Extent of Disability:
Section 61(1)(c)

In this issue, the Medical Review Panel is asked to certify as to the nature and extent of disability and in what ways the disability has affected the body functions of the worker.

Section 61(1)(c) specifically prohibits the Panel from certifying the nature and extent of disability in terms of a percentage of total disability. The Panel cannot certify that the worker has a disability equal to 50% of total disability.

The nature of the disability is simply a description of the disability from which the worker suffers. The extent of the disability is a list of the physical limitations which are placed upon the worker by the nature of the disability. The Medical Review Panel has been asked to describe the extent of the disability in terms of how it affects body functions.

Issue #4 to #6 Cause:
Section 61(1)(d)

"Cause" is defined as "that which produces an effect or gives rise to an action, phenomenon, or condition" or "that which brings about any condition or produces any effect"[30]. In this Issue #4, the Medical Review Panel is asked to certify as to whether the worker's compensable injury was of "causative significance" in the disability and if so, in what way.

"Cause" refers to the etiology of the disability. It means "cause" insofar as it is a matter of medical science, but not "cause" insofar as it is a matter of moral value judgements, law or non-medical facts.

#103.54 of the *Rehabilitation Services & Claims Manual* gives the following example:

"Suppose, for example, a worker suffers an injury to his hand by catching it in machinery at work. During subsequent medical treatment in hospital, he suffers an infection. The infection results in a disability far greater than would have resulted from the original injury. Suppose then that the question raised is whether the ultimate disability was "caused" by the work injury. That is a broad issue that really incorporates several questions, some medical and some non-medical. The responsibility of the Panel in a case of this kind is to consider whether the Board or Review Board has arrived at correct conclusions on the medical aspects of the matter, i.e., correct conclusions on how and where the infection was contracted, and the medical significance of the infection. But whether the consequences of the infection should be treated as consequences of the original injury for compensation purposes is a question of law and policy and that the Board or Review Board must decide for itself."

In Issue #5, the Medical Review Panel is asked to certify as to whether the worker's disability was wholly or partly the result of causes other than the compensable injury and if so, how and to what extent each other cause was significant.

In Issue #6, where there are two or more causes of the worker's disability, the Medical Review Panel is asked to certify, as to the role of each cause, whether each cause acted independently or together with some other cause and the proportion of disability that can be attributed to each cause.

It is open to the Medical Review Panel to consider all other possible causes of the worker's disability, including any and all previous work injuries other than the injury that is in direct consideration by the Medical Review Panel.

Issue #7 Temporary Disability:
Section 61(1)(e)

Issue #7 asks the Medical Review Panel whether the worker has been temporarily disabled for any further periods of time beyond those which have already been recognized by the Board. On the basis of the Panel's answer to this question, the Board determines whether the worker is entitled to any further benefits for temporary total or temporary partial disability. The term "temporary total disability" refers to benefits for temporary total disability paid when a worker is completely disabled from returning to any type of work following a compensable injury. These benefits are commonly referred to as wage-loss benefits (Section 29). The term "temporary partial disability" refers to benefits for temporary partial disability being paid when a worker is completely disabled from returning to the work he or she was doing at the time of the injury, but is not disabled from doing some other type of suitable work. (See Section 30 of the Act.)

Issue #8 Pre-existing Disability or Condition

Note that Issues #8 and #9 do not directly parallel any of the sections on the Panel's jurisdiction as set out in Section 61(1).

In Issue #8, the Panel is asked whether the worker suffered from any pre-existing condition or disability prior to the compensable injury.

The question as to whether a pre-existing problem amounted to a "condition" or "disability" is the key to the determination as to whether the Board has any responsibility for that pre-existing problem.

Section 5(5) of the Workers Compensation Act provides as follows:

"Where the personal injury or disease is superimposed on an already existing disability, compensation shall be allowed only for the proportion of the disability following the personal injury or disease that may reasonably be attributed to the personal injury or disease."

In his review of the workers' compensation system in 1967 (2), the Honourable Mr. Justice Tysoe wrote as follows:

"It should be noted – and I think this is the key to the apportionment – that pre-existing disability and pre-existing condition are not synonymous terms. Condition is a general word and if there are other things with it, it may constitute a disability. It is disability that counts in workers' compensation and not mere condition."

Item #44.10 of the *Rehabilitation Services & Claims Manual* sets out the Board's policy with respect to the meaning of "already existing disability" as follows:

"The mere fact that the worker suffered from some weakness, condition, disease or vulnerability which partially caused his personal injury or disease is not sufficient to bring proportionate entitlement into operation. The pre-existing condition must have amounted to a disability prior to the occurrence of the injury or disease."

The question as to whether a pre-existing problem amounts to a condition or disability is not solely a medical question. It is a question of law and compensation which has a medical component. Once the medical question is answered, the Board must answer the law/compensation question in accordance with the policy.

The Medical Review Panel's jurisdiction in Issue #8 is limited to describing the nature of pre-existing problems and how they may have affected the worker's physical functioning prior to the compensable injury. The Panel should not attempt to classify the pre-existing problem as a disability or condition as this would be determining compensation entitlement.

In Issue #8, the Medical Review Panel is also asked to certify whether the pre-existing problem was activated, accelerated or aggravated by the compensable injury.

The use of the word "activate" indicates that the pre-existing problem had no effect prior to the compensable injury. It suggests the compensable injury rendered the pre-existing problem symptomatic.

The use of the word "accelerate" does not really indicate whether the pre-existing problem was symptomatic or not. It just suggests that a pre-existing problem began to increase following the compensable injury, whether symptomatic or not.

The use of the word "aggravate" indicates that the pre-existing problem had an effect prior to the compensable injury that suggests the compensable injury rendered the pre-existing problem more symptomatic than before the compensable injury.

The Panel's choice of the word activate, accelerate or aggravate under Issue #8 is very important in the Board's determination as to whether a pre-existing problem amounted to a condition or a disability.

### Issue #9 Permanent Disability

Benefits for permanent, total disability are paid when a worker is left permanently and totally disabled by a compensable injury as a result of performing any type of work. Some examples of permanent, total disability according to the *Rehabilitation Services & Claims Manual* are paraplegic, quadriplegic and total blindness.

Benefits for permanent partial disability are paid when a worker is left with some degree of permanent, physical impairment as a result of a compensable injury. These benefits are commonly referred to as a PPD or pension.

Issue #9 asks the Medical Review Panel whether the worker's disability has changed to any significant extent since its commencement, what the nature of that change might have been, and whether any further change is expected in the next 12 months. On the basis of the Panel's answer to this question, the Board determines whether the worker's disability is permanent and at what point in time the disability was likely to have become permanent.

The Panel's answer to Issues #3 and #9 are used by the Board to determine whether the worker is entitled to further benefits for permanent, total or permanent, partial disability.

The worker and employer have an opportunity to review the Statement of Non-medical Facts and Issues and make comments as to their completeness and accuracy prior to the statement going to an MRP. Disputes may be appealed.

Medical Review Panels can be used in fatality claims as well as in disability claims. The sole issue, however, is to determine the cause of death. Only dependants (not employers) may request an MRP and no certificate is needed indicating that a bona fide medical issue exists. As well, there is no requirement that an appeal for an MRP be made within 90 days of the WCB decision. (See Appendix 9.2 – Forms for Dependants Desiring an Inquiry into the cause of Death of a Worker.)

## THE DESIGNATION OF SPECIALTY

The Panelists are physicians and/or surgeons with specialties relevant to the occupational injury/disease under dispute (see Table 7). "Specialist" means "a physician residing and practicing in the province and listed by the Royal College of Physicians and Surgeons of Canada as having specialist qualifications" (the Act, Section 1). There are 24 specialties available. (See Table 7.)

The assignment or designation of specialty is made by the Registrar, Medical Review Panels. Previously, this was done by a senior Medical Officer within the Medical Services Division of the WCB. The Registrar reviews the complete file, including the complete history, physical examination findings and any diagnostic testing that was undertaken, as well as the statement of foundational non-medical facts and issues compiled by the Medical Appeals Officer.

Once the specialty has been designated, the worker and employer then each have the opportunity to nominate, in order of preference, three specialists from a list of specialists which have been appointed by the special joint medical committee of the College of Physicians and Surgeons of British Columbia and the BCMA (see Table 6 and Appendix 4). On the basis of availability, the highest-ranking choices are appointed to the Panel.

Currently, specialists may remain on the list indefinitely, as long as they remain in good standing with the BCMA and the College of Physicians and Surgeons of B.C., and remain in active practice of their given specialty.

The most frequently used specialty is orthopaedics (see Tables 8.1 and 8.2). A distant second is neurology.

The most common medical issue presented to Panels is back injury, with chronic pain.

## THE FORMATION OF THE PANEL: CHAIRMAN AND SPECIALISTS

The Lieutenant-Governor-in-Council appoints physicians to serve as Chairmen of Medical Review Panels. They are, thus, Order-in-Council appointments. Currently, 14 physicians serve in this capacity. Table 9 depicts the Medical Review Panel Chairmen and their dates of appointment. Appendix 3 gives the synopsis curriculum vitae of the Panel Chairmen. A Panel Chairman is named on the basis of availability and priority of distribution by the scheduling clerk of the Medical Review Panel Department.

When the Board accepts an appeal for an MRP, the Department sends a list of Specialists practicing in the field in which the medical dispute occurs to the worker and to the employer, asking them to choose a Specialist. The worker and employer then each have the opportunity to nominate from this list, in order of preference, three Specialists. This list is compiled by a special medical committee appointed by the Lieutenant-Governor-in-Council from joint membership of the College of Physicians and Surgeons of B.C. and the BCMA (see Table 6). On the basis of their availability, the highest-ranking choices are appointed to the Panel providing there are no disqualifying factors (see Table 10) for a Specialist, making him or her ineligible to sit on a given MRP.

The Panel Chairman and the two Specialists then meet the worker, customarily at the Chairman's office. The Medical Appeals Officer has, by then, sent to the Panel Chairman the non-medical findings, all the salient, pertinent medical information and any medical reports contained in the claim file ('split file'). The Chairman usually receives these two to three weeks prior to the scheduled date of the Panel. He/she reviews this split file, highlights data and prepares a focus for the specialty members when they meet. Each member of the Panel physically examines the worker. A medical history is taken as well. The Panel is able to request that other tests be conducted if they believe it to be necessary. They are also free to have additional consultation, if it is felt to be required, from other Specialists.

Representation may be submitted in writing to the Medical Review Panel. Personal representation is not common, except in instances where translation is required or at a Medical Review Panel on a fatality issue. The presence of representatives is subject to the approval of the Panel deciding on a fatality claim or for any other purpose.

# THE CONDUCT OF THE MRP[18]

In conducting a Medical Review Panel examination, Section 61(5) (Appendix 5) provides "the Panel shall determine its own procedure." This means that it is entirely up to the Medical Review Panel to determine how it will conduct its examination of the worker and consideration of the issues. The Board has no authority to issue instructions to a Medical Review Panel about the procedure it follows. (See also the *Rehabilitation Services & Claims Manual* #103.44 "Procedure of the Panel" in Appendix 7.)

The Medical Review Panel considers evidence. A definition of "evidence" is:[30] "All the legal means, exclusive of mere argument, which tend to prove or disprove on matter of fact, the truth of which is submitted to judicial investigation."

Oral evidence, obtained in the context of a Medical Review Panel examination, would generally be received at the examination of the worker. In the context of a Medical Review Panel examination, the written evidence would generally be the worker's claim file. The written evidence would also include the Statement of Foundational Non-medical Facts. The Statement is prepared by the Board as has been discussed in the foregoing. It begins with the identification of the medical decision that is in dispute and contains the conclusions relating to the non-medical facts and finally the questions on which the Panel decision is needed (see issues in the foregoing). The worker and employer are invited to comment on this document before it is submitted to the Panel. The Medical Appeals Officer determines any dispute on the statement of foundational non-medical facts. (#103.41 *Rehabilitation Services & Claims Manual* – Appendix 7) Other evidence that might be useful in Medical Review Panel examinations would certainly also include X-Rays and other technical results for medical testing.

Section 61(4) provides: "The Panel may receive and accept the evidence that in its discretion it may think fit and proper and essential to the medical problem to be decided."

Section 103.42 of the *Rehabilitation Services & Claims Manual* provides: "The Medical Review Panel must therefore accept the decisions of the Board or the findings of the Review Board on questions of non-medical fact, while the Board or Review Board must accept the conclusions of the Medical Review Panel on questions of medical expertise."

The non-medical conclusions of fact that have been made are contained in the Statement referred to in the above discussion and in #103.41 in the *Rehabilitation Services & Claims Manual*. The Statement of Non-medical Facts will contain the relevant facts as found by the adjudicator, the Review Board or the Appeal Division. Any non-medical facts that are necessary for consideration in the medical issue and that have not been expressly found by one of the adjudicating bodies will be determined by the Medical Appeals Officer from the evidence, and when there is not sufficient evidence, he/she will obtain the further evidence required. If it appears to the Panel that anything in this statement is significantly wrong or if the Medical Review Panel requires significant additional non-medical facts for its conclusion, the matter is referred back to the Board for clarification or addition to the Statement of Non-medical Facts.

Medical issues rarely involve absolutes. It is recognized that medical science cannot always provide definite answers. There will be cases where conclusions can only be stated in terms of "probabilities". It is anticipated that a Medical Review Panel will sometimes express conclusions in terms of probabilities rather than certainty. It is not necessary that the Medical Review Panel be able to say something is so with 100% certainty. A statement that the conclusion is probable is sufficient.

However, the use of the word "possibility" creates confusion. Reports that speak to possibilities are considered by the Board to be speculative in nature. Reports that speak to probabilities are considered to speak to the likelihood of a conclusion that is given more weight. The words "possibility" and "probability" can not be used interchangeably. "Possibility" indicates that a conclusion might or might not be true, while "probability" indicates that a conclusion is likely to be true.

Section 99 of the Workers Compensation Act, (10 - 15) provides: "The Board is not bound to follow legal precedent. Its decision shall be given according to the merits and justice of the case and, where there is doubt on an issue and the disputed possibilities are evenly balanced the issue shall be resolved in accordance with that possibility which is favorable to the worker."

The Panel Chairman takes great care in placing the worker at ease. The Chairman clearly indicates that the Panel is an independent body, that it has no bias, and that it will examine the facts in the fairest way possible. Following the history-taking and the physical examination, the three physicians then discuss their findings and a report for the file is prepared by the Chairman. The Chairman drafts a Certificate and distributes it to the Specialists for their approval. Only two of the three Panel members need agree, but each member of the Panel signs the Certificate. The Certificate contains answers to the questions the Panel was charged with. The Chairman also drafts a Narrative Report.

## THE MRP CERTIFICATE

The Certificate, then, is the Medical Review Panel's response to the nine or 10 issues posed by the Board. (See previous discussion regarding the Statement of Non-medical Facts and the Issues on pages 19-25.)

Within a reasonable period of time after the examination of the worker, the Chairman is required to certify the results of the examination of the Board, as set out in Section 61 of the Act. (Appendix 5)

The Certificate of a Medical Review Panel is conclusive as to the matter certified. It is binding on the Board. It is not open to question or review in any court, and no proceedings by or before the Panel shall be restrained by injunction, prohibition or other process or proceeding in any court or be removable by certiorari or otherwise in any court. (Section 65)

A most important part of the Medical Review Panel process is the preparation of the Certificate, which contains the Panel's decision. As stated in the foregoing, the Certificate is final and binding upon the Board and the Board must implement the Panel's medical decision in strict accordance with the Certificate. The Certificate must be clear, concise, and, most importantly, unambiguous. If a Medical Review Panel prepares a Certificate that contains an ambiguity, it runs the risk that the Certificate will not be interpreted as it had been intended. The Board must be able to determine the worker's further compensation entitlement on the basis of the Medical Review Panel Certificate.

There are provisions in the *Rehabilitation Services & Claims Manual* for seeking clarification from the Medical Review Panel where necessary. This is further discussed below under MRP Certificate Implementation. However, there is no provision for seeking clarification in the Statute, and the legal standing of a Letter of Clarification on the final binding Certificate is tenuous.

## THE NARRATIVE REPORT

Section 61(2) allows for a Narrative Report compiled and prepared by the Chairman of the Medical Review Panel to accompany the Medical Review Panel Certificate. This document is not legally binding on the Board as is the Medical Review Panel Certificate. The reasons for the decisions are sometimes included within the Narrative Report by some Chairman. The Narrative Report is a detailed document summarizing and focusing on the data provided by the Board, with regard to the file information, the detailed findings of the history-taking and the physical examination. It will sometimes contain sensitive personal medical information recommending a form of action beneficial to the worker's condition.

## MRP CERTIFICATE IMPLEMENTATION

The Certificate of the MRP is returned to the Medical Appeals Officer of the MRP Department, documented and then referred on to the claims adjudicators of the Compensation Services Division, who have been responsible for reviewing Certificates directly since June 3, 1991. It must at that time be reviewed for the possibility that the Panel has overstepped its jurisdiction and to ensure that the intent is clear and not ambiguous. If the Certificate is within the Panel's jurisdiction and the intent is clear, the issue is resolved decisively.

If there is a need for clarification, the adjudicator, after consulting with his/her manager, will send the Certificate to a specialized group, the Executive Policy Advisors. They advise the Vice-President of Compensation Services Division on the most appropriate action and, in consultation with the MRP Registrar, the Certificate is reviewed (see Appendix 11). The procedure for implementation is as set out below in the following guidelines, which are included in Appendix 11 in more detail.

- Certificates will continue to be forwarded by the Medical Review Panel Department directly to the claims adjudicator. The claims adjudicator will proceed with the implementation of the Certificate.

- If the claims adjudicator feels that there is a serious problem with a Certificate and would like assistance, the manager should be immediately consulted. This may be followed by informal consultation with other persons having experience in this area.

- Failing resolution to the above process, the claims adjudicator may, with approval of the manager, formally refer the Certificate to an Executive Policy Advisor, Research and Policy Section. This should only occur in exceptional cases where one of the following situations exists:

    - The Certificate contains an inconsistency or ambiguity for which clarification from the Panel is required or desirable;

    - The Certificate contains decisions on areas outside the authority of the Panel which cannot be accepted;

    - Significant new evidence has been received which indicates the Panel made a fundamental mistake, and should be reconvened. (See #103.58 of the *Rehabilitation Services & Claims Manual* – Appendix 7.)

- The executive policy advisor will review the referral and where appropriate invite comment from the worker and employer or other parties concerned. The executive policy advisor may then forward the matter to the Vice-President, Compensation Services Division for a decision and for consultation with the Registrar, MRP.

- The above process should also be followed if a worker, employer or Ombudsman is disputing one of the situations outlined in the above paragraphs.

# 2.2 APPOINTMENT PROCESS OF CHAIRMEN AND SPECIALIST MEMBERS OF MRP

## CHAIRMEN

The appointment of Chairmen is by Order-in-Council by the Lieutenant-Governor-in-Council. The appointment is without term. As indicated earlier, Table 9 depicts the Medical Review Panel Chairmen and their dates of appointment.

There are no established guidelines available for appointing MRP Chairmen.

There are no guidelines for the termination of an appointment for cause.

In general terms, Chairmen are seen by their peers as physicians or surgeons with broadly based medical knowledge, good judgement, clinical experience, and ability to express their decisions with clarity. Currently, there is no formal, stated list of qualifications, nor a job description or guideline of duties and functions. Panel Chairmen are currently not required to have knowledge of occupational medicine or industrial work sites nor a specialty certification in occupational health and safety.

## SPECIALIST MEMBERS

The current practice in the appointment process of Specialist Members of the MRP is by a joint committee of the College of Physicians and Surgeons of British Columbia and the BCMA, appointed by the Lieutenant-Governor-in-Council. (see Section 58(2); Table 6 depicts the composition of the joint medical committee). The current practice of joint committee members being selected is by nature of their position (see Table 6). Appendix 4 depicts the Specialists available to serve on Medical Review Panels along with their short biographical notes. Table 7 summarizes the specialties available for MRP Panels. Tables 8.1 and 8.2 illustrate the frequency of Specialists used in MRP. Currently the Joint Committee has been meeting on a regular basis and updating the list of Specialists. The community of physicians and surgeons has been notified by the BCMA as to the opportunities to serve on Medical Review Panels.

## 2.3 EDUCATION/TRAINING OF CHAIRMEN, SPECIALIST MEMBERS, MRP DEPARTMENT STAFF

There are current orientation guidelines for new Chairmen (see Appendix 10.1) and Specialist Members (see Appendix 10.2 ). An initial Chairmen's Educational Day was held for the first time on May 29, 1992. A summation of the program is depicted in a brochure (Appendix 14) and in an appraisal (Appendix 15). Currently, funding support to Chairmen, Specialist members and MRP Department staff for extensive training and education sessions has not been recognized in the budget, except for the initial program of May 29, 1992.

The Chairmen have tended to work in isolation and have no knowledge as to the implementation of their Certificates, and have no interchange with the decisions of other Panels. To date they have not been made aware of court decisions or Appeal Division decisions with respect to the MRP process on an ongoing basis. The Chairmen's Education Day initiated many of these processes.

## 2.4 MEDICAL REVIEW PANEL QUALITY ASSURANCE

There is no formal quality assurance monitoring process for the performance of Chairmen or Specialist Members of MRP Panels nor of members of the MRP Department staff. The Registrar has reviewed some 300 Certificates during the time of his appointment since September 1, 1991, monitoring the quality of the Certificates as to clarity and format, and the time flow between the examination and when the Board receives the MRP Certificate.

## 2.5 THE POSITION OF REGISTRAR, MEDICAL REVIEW PANELS

This appointment was made on September 1, 1991, for a one-year period. The description of the position is in Appendix 1. It is a consultative position, filled by an independent physician. The terms of reference are essentially related to two mandates:

1. To oversee the administration, policy and procedure of the Medical Review Panel process; and

2. To review the administrative policy and procedural, functional activity of the Medical Review Panel process and to identify issues and recommendations for improving the process.

The Registrar, Medical Review Panels, can play a pivotal role in interrelating the MRP Department with relevant internal WCB areas. There is also a significant role for interplay with the community of workers, employers, and their representatives. The Registrar has a major role in interrelating with the Chairmen of the MRP and facilitating their activity and those of the Specialist Members of the Panels. In essence, the Registrar can serve the role of "key gatekeeper" with respect to the problems arising from implementation or development of the Certificate. (See also the following Section 2.6 - MRP Administration and Appendix 1 – Position Description.)

## 2.6 MRP ADMINISTRATION

The Registrar, Medical Review Panels – and, more specifically, the Manager – are responsible for generally overseeing the administration, policy and procedures of the Medical Review Panel process, including reviewing the administrative functions performed in preparation for a Medical Review Panel examination. This includes the determination as to whether a Bona Fide Medical Dispute has been defined, as well as the preparation of the Statement of Foundational Non-medical Facts and Issues, the preparation of the file, and the gathering of additional medical evidence.

In addition, the Registrar provides advice and assistance to the Medical Appeals Officers in the performance of these administrative functions, as required, from time to time:

- Reviewing all Medical Review Panel Certificates received by the Board with a view to highlighting difficult areas and providing the Board with feedback in cases where the Medical Review Panels are in disagreement with the Board;
- Adopting a leadership role among the Medical Review Panel Chairmen with a view to facilitating regular communication between the Medical Review Panel Chairmen;
- Establishing a program for orientation, training, ongoing education and communication for the Medical Review Panel Chairmen (see Brochure - Appendix 14 – Medical Review Panel Education Day May 29, 1992);
- Developing criteria and procedures for the recruitment and selection of new Specialist Members and Medical Review Panel Chairmen.

The Medical Appeals Officers are the backbone of the administrative MRP process, but there is also an excellent team spirit between the Medical Appeals Clerks and the Medical Appeals Officers.

## 2.7 INTERACTIONS WITH GROUPS AND REPRESENTATIVES

The Medical Review Panel's process is an independent system. It is not only independent, but it must be *seen* to be independent, fair, and free of bias and political influence, with the principles of natural justice applied consistently.[35] However, the process does not function in isolation. Interaction with significant groups, as well as feedback and the exchange of views, is by and large helpful in determining the final outcome and performance of the process. In some instances, of course, it may delay the decision or the implementation of the MRP Certificate and increase the costs associated with the MRP function.

Within the Workers' Compensation Board there is active interchange and communication between the MRP, the Appeal Division, the President of the WCB, the Compensation Services Division (including Managerial Review), the Medical Services Division, and the Occupational Health & Safety Division, particularly the Occupational Health & Safety Department. Within the medical community, there is active communication with the joint committee of the BCMA and the College of Physicians and Surgeons of BC, the Chairmen of Medical Review Panels and the Specialist Members of the Medical Review Panels. Within the non-medical community, there is active interchange at all phases of the Medical Review Panel process with the Review Board, the worker, employer, Workers' Advisors and Employers' Advisors Offices, both legal and union representatives, the Ombudsman's Office, the WCB Advocacy Group, and the community at large.

# SECTION 3

# MEDICAL REVIEW PANEL PERFORMANCE AND OUTCOMES

Medical Review Panel performance and outcomes are presented in the five following headings in this section: Frequency of Use; Satisfaction; Time Phases through the MRP process: Possible Delay Factors; Costs; and Features that Contribute to Success or Failure of the MRP process.

Data relating to the following sections on MRP performance and outcomes can be found in Figures 3-5, and Tables 3-5 and 11-15.

## 3.1 FREQUENCY OF USE

Almost all MRP cases involve appeals by workers. The most common issue that goes to an MRP is the question of causality or work relatedness of the condition. A second very common medical issue is the evaluation of the worker's condition. Though many types of conditions are assessed by MRPs, not surprisingly back conditions and those associated with chronic back pain are the ones most commonly involved. The predominant specialty that is chosen or designated is orthopaedic surgery (see Tables 8.1 and 8.2). Approximately 73% of the Panels held in 1991 comprised orthopaedic surgeons, and this compares to a similar percentage of the Panels held from January 1 to June 30, 1992. Table 12 indicates the number of Panels held per annum for the past five years.

The trend is for increases in applications each successive year (see Table 3). 1991 saw a record of more than 500 applications (Figure 3, Tables 2-4) and to date, figures in 1992 show no decrease but some increase over that of last year. It is significant that, at year end in 1991, there were 442 applications awaiting attention by the MRP or in process of moving through the system (Table 3). The backlog is increasing as the number of applications awaiting processing has increased appreciably over the past three years (Tables 3-4).

As of June 30, 1992 there were 485 MRP applications awaiting consideration and being processed (Table 4). New MRP applications had jumped to 623 as of May 31, 1992 (Table 2).

Figure 2 and Table 2 indicate the source or access of MRP applications. By far (some 54% during 1991), the greatest numbers arise from activity generated by the Appeal Division as part of their backlog clearance. It is unlikely that this increase in applications will abate in the near future.

Despite this trend, the number of Panels held has not increased. There is a slight decrease in 1991 (see Figure 4 and Table 12). In fact, over the past five years there has been some decrease. The transition from Appeal Division to an independent separate department, with its loss of support staff and initial and continuing deficit in Medical Appeals Officer personnel, has been a major contributing factor to this state of affairs. In addition, there has been an increase in the complexity of many medical issues referred to the Medical Review Panels.

During 1991, there were 203 Certificates implemented.

It is important to realize that the importance of these statistics is not so much the number of Panels held in any given year, but rather the number of MRP Certificates that have been implemented. The implementation process confirms the finalization of the decision of the Certificate.

It is interesting to observe the time factors between the Board's receipt of the application and the follow-through of the entire process at each phase of its development, until the actual time of implementation. In 1991, the total time was an average of 400 days (see Figure 3). (See also Section 3.3 - Time Phases Through the MRP Process: Possible Delays.)

## 3.2 SATISFACTION

In all of the interviews with the Chairmen, the Specialist Members and the 52 interviewees within the Board and community, there was no suggestion that the Medical Review Panels should be discontinued. In most instances, there was a high degree of satisfaction with the process. Even when issues were raised, there was strong support for the fact that a final binding decision was being made on a medical dispute, relieving the burden on Board administrators, representatives and legal counsel alike. The process in most instances avoids additional delays and costs, albeit it might not be as efficient as it could be. However, in comparison to the time involved in the appeal and dispute resolution process, where the measurement of time was in years, time involved in passing through an MRP process was measured in days. Generally speaking, the interviewees felt that the Panel findings were an independent source of usually consistent decisions based on objective evidence.

The outcome of decisions, which have been quite consistent over the past five years (see Tables 12-14 and Figures 3 and 5), are quite interesting, with a 50% decision against the Board, 10% partially against the Board and 40% upholding the Board. These figures reflect, to some extent, the satisfaction of the claimant, less so the satisfaction of the employer or the Board.

If the Panel is conducted as it should, even when a decision is against the appellant, there is at least a final binding decision made by a group of expert, independent, unbiased, non-political physicians. The appellant should feel that he or she has been dealt with fairly.

Why the relatively high percentage of decisions against the Board, and with some Chairmen as high as 76% (see Table 14) exists, is open to many conjectural explanations. An analytical study of this would be a worthy project in itself.

With respect to Table 14, the variations in Panel decisions related to the Chairmen might not be as significant as first seen. It is important to remember that the Medical Review Panel, as a whole, makes the decision – not the Chairman alone. The percentage of Panels that did not confirm Board decisions is therefore not truly a reflection of any given Chairman. Also, the percentages are somewhat skewed by the numbers of Panels involved. The Panels under 15 appear at the lower and upper extremes of the percentages.

The most common source of WCB reversals on medical issues is alleged to be where WCB doctors have not seen or examined the worker. There are surely many other factors at work here. Currently there is no data available to demonstrate conclusively whether this reversal rate is excessive. It certainly is consistent in a 5-year period (see Tables 12 and 13).

It is important that a reason for the decision of the MRP be given – this is not always done. This would be helpful in providing feedback mechanisms to those who had been involved in the development of the process, including adjudicators, Board physicians and representatives. Feedback mechanisms are not as active as they should be in this regard. Attention to this would provide a powerful, helpful tool in the educational process of those concerned, including the Chairmen and members of the MRP.

## 3.3 TIME PHASES THROUGH THE MRP PROCESS: POSSIBLE DELAY FACTORS

Figure 3 demonstrates the Medical Review Panel process volume and time flows. Typically, the Panel process took an average, in 1991, of 400 days from the time the referral of application is received until the implementation of the certificate. An analysis of the factors leading to the time periods in Figure 3 is underway currently. An effort is being made to make the process more efficient and reduce delays to an absolute minimum.

Figure 3 is a helpful depiction of the volume and time flows of the MRP process and focuses on the overall picture:

- It took an average, in 1991, of 400 days to complete the entire process from application to MRP Certificate implementation.
- 63% of this time was taken up in the process of receiving applications to the time of scheduling the Panel:

    a) 10% of the time was taken from the time the applications were received to the development of the Physician's Enabling Certificate;

    b) 22% was time involved in developing the Enabling Certificate;

    c) 23% of the time was from receipt of the Enabling Certificate to the development of the Statement of Non-medical Facts and Issues by the MAO;

    d) 8% of the time was spent from the development of the statement of non-medical facts and issues until the designation of a specialty.

- 37% of the time was taken from the MRP examination to the implementation of the Certificate:

  a) The scheduling process from the time the designation of a specialty is made until the MRP exam required 17% of the time;

  b) The time from the MRP examination until the MRP Certificate was received at the Board required 10% of the time;

  c) The time from the MRP certificate being received and implemented was 10% of the total time.

It is interesting that, during 1991, the average time taken for the Panel Chairmen to complete the Certificate, from the time of the examination until the Board received the certification, was 40 days, or 10% of the total time. Since the Chairmen's Education Day of May 29, 1992, where a review of the performance of Chairmen was presented, this time has decreased to 21 days on average. The potential value of a quality assurance monitoring system is clear.

A criticism of the MRP process is that it delays the outcome of the claim or at least a resolution of any medical disputes. In spite of the time that most of the appellants have spent in the system in recent years, prior to coming to the MRP, 400 days still seems like a relatively long period. Dispute resolution processes, in themselves, provide delays and cost factors. However, delays introduced by the use of MRPs must be balanced against the expedited settlements stimulated and finalized by Panel Certificates. The delays arise in evaluating the request for the appeal, the need to prepare the files to go to the Panels, scheduling the examination, arranging for the necessary medical diagnostic tests, getting agreement and final sign-off on the report and Certificate, and agency follow-up questions to the Panel in the implementation process. Some evidence suggests that the time to complete the MRP process has been reduced in recent years (see Table 5). The MRP Department has collected data on the time it takes from the receipt of the appellant's doctor's certificate to the date of file closing. In cases where requests were received in 1984, it took 1,293 days, declining in 1988 to 434 days, and to 400 days in 1991 (see Table 5).

Delays in implementation, once the medical certificate has been received by the Board, have occurred as a result of requests from the Compensation Services Adjudicators, a variety of representatives of the worker or employer on grounds of a need for clarification, requests for a reconsideration or even a request for reconvening, or declaring the certificate null and void. Although these occurrences are not common, when they do occur they are very complex and timely in processing and finalizing. Issues involved with this problem of implementation and appeals for reconsideration, clarification, and reconvening have been identified and addressed in the Issues and Recommendation sections. They have also been discussed under Section 2.1 – MRP Certificate Implementation.

## 3.4 COSTS

Prior to the development of the MRP Department, costs were not readily identifiable. Since the Medical Review Panel administration has become a separate department with its own budget, a clearer identification of the costs associated with medical participation and some semblance of the cost of operating an MRP process are emerging. These are summarized in Table 15.

The direct costs of Medical Review Panels depend on the volume of cases, the number of Panel Chairmen and their fees, and the number and types of MRP staff. The projected budget for 1992 for the MRP Department is $585,250. The medical-aid component – that is, the cost associated with the Chairmen and Specialist Members of the MRP – during 1991 was $461,337, giving a total annual budget of $1,046,587. On the basis that applications received totaled 500 during 1991 and the MRPs held and implemented was 203, the cost per Panel in relationship to the MRP Department operational budget alone was $2,883, on medical-aid alone was $2,272, on applications received was $2,093 and on the basis of MRP held and implemented was $5,145, related to the MRP Department and medical-aid components combined. It should be appreciated that these figures are somewhat of a mishmash, in that the Department has not been formed for a full year and the budget is a projection budget on the basis of the 1992 experience (January to May 31, 1992) and the medical-aid component is on the 1991 experience (Table 15).

## 3.5 FEATURES THAT CONTRIBUTE TO THE SUCCESS OR FAILURE OF THE MRP PROCESS

The MRP process is considered a success in British Columbia by all parties. That it is not immune to criticism is apparent from the number of Issues identified, 158 in all. These are detailed in Section 4.1, followed by the Recommendations resulting from these Issues – in Section 4.2 – of which there are 131.

In order to maintain the system as a success and not let it slip into disrepute or lose its credibility, it is imperative that vigilance and attention be given to the following areas, which will result in an even better system or process:

- Reduce or eliminate causes of delay.
- Maintain and reinforce the binding nature of the decision.
- Continue to enhance the credibility of the Panel Chairmen, and Specialist Members.
- Reduce the need for disputes about the Certificate on the basis of clarification, interpretation, reconvention or even being null and void.

Some comments are appropriate at this time.

On the subject of **credible Panels**, the most critical ingredient of the successful Panel is the involvement of highly qualified, well-respected, objective physicians, both as Chairmen and Specialist Members. This is hardly surprising, but it raises a difficult question of how to attract and retain these doctors. For instance, there was a tremendous drop-off of participation by Specialist Members during the Board/ BCMA fee negotiations. Even now, with matters settled, some specialties remain in short supply – for example, neurosurgeons.

Clearly, in the politicized atmosphere of workers' compensation, there are no guarantees. However, there are several things that must be delicately balanced.

Firstly, **the appointment process** should be as non-political as possible. It must be not only meticulously fair but seen to be fair and aimed at getting the best representatives of the Specialists as possible. Several issues surround the current appointment process. These have been identified and recommendations made in the appropriate sections of the report.

Secondly, **compensation** of the Chairmen and the Specialist Members must be adequate. Currently there is an hourly rate for the Chairmen. As it stands now this rate for Chairmen is fairly comparable to an office practice rate of the specialty consultant. Specialist Members receive a flat rate per Panel, with an hourly rate per hour for additional sessions, if need be, up to a maximum of a cap. Overall, this is a lower rate than a consultant could expect in office work.

There is a secretarial rate per hour allowed for the Chairmen, who then bill the Board for the secretarial assistance.

Payments for Chairmen, Specialist Members and secretaries are all administered through the Medical Review Panel Department which is ultimately relayed through the financial offices of the WCB. The Chairmen, at their meeting of May 29, have expressed the desire to be reimbursed through sources and processes other than those involving the WCB, in order to maintain their independence of the Board.

Thirdly, opposition to **binding decisions** of the medical Certificate should be minimal. Dispute resolution processes can cause significant delays in implementation and can produce misinterpretation of the intent of a Certificate, resulting in possible frustration and discouragement to a Panel. If a Certificate is written with clarity and precision, these delays should not occur. Feedback to the Panel of the implementation is currently minimal.

Sections 1-3 of this document have been an overview of how the MRP process works and some of the more important aspects that make it a success. However, the process can be improved upon and made more efficient, as demonstrated by the issues that have been raised in this report in the following Section 4.1, and as a result of those issues, the recommendations as noted in Section 4.2.

# SECTION 4

# ISSUES AND RECOMMENDATIONS

# 4.1 THE ISSUES IDENTIFIED WITHIN THE MRP PROCESS

There are some 158 issues raised in this report. The issues are presented within the organizational, functional flow of the Medical Review Panel process as outlined in Sections 1-3.

These issues were developed as the result of my reviewing Workers' Compensation Board documents and a widespread search of literature and publications and information received from my interviews (see Appendices 12 and 13). The list of issues was circulated to those interviewees and others (see Appendix 13) and a response and comment to these issues were requested. Of the 64 individuals, groups and representatives who received the list of issues, there was a 65% return rate, with many thoughtful, helpful comments and suggestions.

As a result of this process and because some issues were more easily combined in the related recommendations, the issues listed in this section are not identical to those mailed out (Appendix 12). However, for ease of reader correlation, the headings, subheadings, and numbering used for these Issues – Section 4.1, are identical to those in the following Recommendations – Section 4.2.

The issues raised are as follows:

## I. INITIATING A MEDICAL REVIEW PANEL APPEAL

### Appellant's Request

1. Are criteria for a claimant's request clearly stated?

### Time Limits

2. Are the time factors relevant? Are they too restricted?

3. Should S.58 of the Act be amended to provide specific authority to waive the appeal time (90 days) in appropriate cases? What are appropriate cases? Where should this authority lie?

### Physician's Enabling Certificate Establishing a Bona Fide Medical Dispute

4. What material (evidence) should be available to explain "medical decision" (or "medical finding") criteria to determine existence of a bona fide medical dispute.

5. Are the guidelines to physicians adequate? If not, how could they be improved?

6. Should the Board be able to reject an Enabling Certificate? If so, on what grounds?

7. Should non-physician, health-care givers be able to raise an Enabling Certificate e.g. chiropractors, dentists (oral surgeons), psychologists, etc.?

8. What should the criteria be for accepting a Certificate from an out-of-province physician?

9. Should the criteria for the acceptance of a physician's Certificate from an employer be different from the criteria for acceptance from a worker?

### Administrative Decision-Making

10. Why are there decision delays?

11. What can be done to eliminate such delays? (See also I-10.)

12. Who should make the determination as to whether an out-of-province physician's Certificate will be accepted? (See also I-8.)

13. Who should be responsible for deciding whether a bona fide medical dispute has been established? What does "sufficient particulars to define the question in the issue" mean?

14. What additional skills and training are required for a Medical Appeals Officer?

## II. STATEMENT OF FOUNDATIONAL NON-MEDICAL FACTS AND ISSUES

### Non-medical Facts

1. Should the Medical Review Panel (MRP) be bound by the Board's findings of non-medical facts?

2. How should the MRP deal with "new facts" or "disputed facts" which emerge during the history-taking by the Panel?

3. Who should be responsible for reviewing the file to obtain any additional medical records which might be relevant to the decision in dispute which are not found on the claim file?

4. Should the Panel be provided with the whole claim file or as is the case currently, with the "split file"?

5. Is it necessary for the Board to prepare a Statement in every case?

**Issues**

6. Are the guidelines for preparation adequate?

7. Are the questions always specifically and adequately relevant to the issues raised?

8. Should an appeal to a MRP be available under Section 39(1)(3) (#103.11 from *Rehabilitation Services & Claims Manual*) which allows the Board to relieve employers of the costs of a claim where a portion of the disability has resulted from the enhancement produced by a pre-existing disease, condition or disability?

## III. DESIGNATION OF SPECIALTY

1. Currently the Registrar designates the speciality. Is the process of how this is done, appropriate?

2. Do the issues in dispute always clearly lie in one specialty only? If not, how should this be managed?

3. Should the Specialty of occupational health or occupational medicine be used in claims for repetitive strain injuries, exposure to toxic substances, or other injuries with disabilities which fall under this heading?

4. Should MRPs be encouraged to make more use of outside resources and consult with specialists in other areas of medicine, or, for example, other non-medical specialists such as psychologists or epidemiologists?

5. How should Chronic Pain Syndrome (CPS) be handled when designating specialties? Are there other special 'common' medical syndromes that should be reviewed in reference to the MRP process? (See also IV-10,11,12,13.)

6. What is the process of interpretation of MRP Certificates when a Panel's understanding of chronic pain and CPS contradicts that of the WCB, the worker, the employer or a representative?

## IV. APPOINTMENT OF CHAIRMAN, MRP

1. Should the terminology of "Chairman" MRP be changed to "Chair"?

2. Should the appointment be made by the Lieutenant-Governor-in-Council? If not, who should have this authority?

3. Should the combined Special Committee of Physicians and Surgeons of B.C. and the British Columbia Medical Association (BCMA) that currently creates lists of Specialists, be the recommending Committee on Chairman? (Note that the Act only refers to a "Medical Committee" (S.58(2) in relation to Specialists.)

4. Should appointments remain without term? If not, what should the term be? Five years renewal subject to review?

5. Should there be a termination process established? If so, what should the guidelines to this procedure be?

6. What qualifications should be required?

7. Should there be specific educational, training programs for new appointments and continuing appointments? If so, what subjects should be covered?

8. Should MRP activities – eg., conduct of Panels, Certificates, narratives – be monitored for quality? How? By Whom? (See also X.)

9. How is the community to be assured as to the fairness of the Appointment process?

10. Should the Panel Chairman be required to have some knowledge of occupational medicine or industrial worksites?

11. Should there be a process for receiving complaints with respect to MRP Chairmen eg. complaints from specialists with respect to certain Panel Chairmen or complaints from workers with respect to their examinations by a certain MRP? (See also V, IX and X.)

12. Should any of the currently appointed chairmen be able to act as an acting Chairman when a Chairman is unable to continue to act in a particular case eg. death of a Chairman? (See Section 58(1).)

## V. APPOINTMENT OF SPECIALIST MEMBERS, MRP

1. Is the appointment process of Specialist Members of a MRP by a "joint committee" of the College of Physician and Surgeons of B.C. and the BCMA (S.58(2) appropriate? If not, who should prepare and recommend the lists of specialists?

2. How should "joint committee" members be selected?

3. Are the numbers of selected Specialist Members to a given to a given specialty adequate?

4. What are the guidelines and criteria used by the "joint committee" for selection of Specialist Members for MRP? What should the criteria be?

5. Are physicians and surgeons in B.C. notified adequately of the opportunity to become a Specialist Member of MRP?

6. Should non-physician health care givers be able to be appointed to Panels?

7. Is the current list of disqualifications for Specialist Members serving on a given Panel adequate? What other disqualifications should be provided for?

8. Who should make the nomination of a specialist on behalf of the Board, when the worker is self-employed, a partner or member of the firm that is the employer, or where the employer has closed its business in the industry in which the injury or disability occurred? (The Board is to nominate the Specialist as if it were the employer under Section 59(2).)

9. Is it necessary for a nomination to be made by the Minister of Labour, in the event the eight-day period after receiving notice is not met? Should this requirement be amended? (See Section 59(4-5).)

10. Are there delays in the process due to Specialists' unavailability? If so, how can these delays be resolved?

11. Should the Specialists list be updated on a regular basis? If so, what mechanisms can be put into place to ensure that regular updating occurs?

## VI. EDUCATION/TRAINING, OF CHAIRMEN, SPECIALIST MEMBERS, MRP DEPARTMENT STAFF

1. Is current orientation for new Chairmen and Specialist Members adequate? (See also IV and V.)

2. Should the WCB improve continuing education training for MRP Chairmen, Panel Specialist Members, instructing them in relevant compensation issues, terminology, role, and jurisdiction of MRP and any relevant issues? Who should coordinate this?

3. Should sessions for Chairmen/Specialist Members be separate or combined? Should other interested parties be invited, eg. lawyers?

4. Should there be funding support to Chairmen, Specialist Members, MRP Department staff, for attendance at training/educational sessions?

5. Should there be a process for periodically bringing the MRP Chairmen together to discuss common issues? If so, what process should be instituted?

6. Should there be a process for advising the MRP Chairmen about the results of the examinations of other MRPs and keeping the Chairmen generally informed of the decisions of other Panels?

7. Should the MRP Chairmen be provided with copies of Court decisions issued with respect to the MRP process?

## VII. MRP CERTIFICATE

1. Should there be guidelines for a format? How should they be developed?

2. Should there be monitoring of quality of the Certificate? If so, what form should it take? Who is responsible for this?

3. As part of the MRP Certificate should reasons be given for the decision?

4. Should there be time limits for Panels issuing Certificates?

5. What are the processes for managing a need for clarification? Are they now adequate? Should there be criteria and guidelines as to when clarification should be sought? Why should clarification be needed at all? (See also VII-1,2,3,13.)

6. Are there problems with the Board's interpretation and implementation of Certificates?

7. Are there differences in process between the adjudicator requiring clarification to implement the Certificate and afterwards when an external party asking for clarification because they dispute the implementation?

8. Should feedback (eg. to MRP, WCB Medical Services) be more effective? Should feedback incorporate how each Certificate has been "interpreted" and "implemented"? Will feedback be different for the "MRP" and for the "WCB Medical Services"?

9. Does the Board have the authority to declare a Certificate "null and void" - to declare a Certificate beyond the jurisdiction of a Panel? If so, what are the criteria to do so? If not, should the Board have the authority and on what grounds?

10. Is the distribution of the Certificate adequate? Should there be any restrictions on this? Are there Access to Information Privacy considerations?

11. What are criteria for requesting reconvening of an MRP? What happens if the criteria are met, but the MRP cannot be reconvened because of the death of the Chairman or a Specialist Member of the Panel?

12. What happens if new evidence arises after an MRP Certificate has been issued? What are criteria of new evidence? Who decides if it is new evidence?

13. Does new evidence impact on the binding nature of the Certificate?

14. Should an MRP Certificate be referred back to the Panel for clarification before a claims decision is made when the Certificate is disputed by the appellant's physicians?

15. How long are MRP Certificates valid for?

16. Should the Chairmen/Registrar, MRP have access to independent legal counsel when it is felt that the Board is usurping jurisdiction of the Panel or when there is disagreement with the Board at Law?

## VIII. MRP NARRATIVE REPORT

1. Is the purpose of the narrative report clear? Are the guidelines adequate?

2. Are there procedures for clarification of contradictions with the Certificate? If not, how should contradictions be resolved?

3. Is the narrative report legally independent of the Certificate?

4. Should the narrative report be used to provide the reasons for the Panel's decision instead of restating the facts and the evidence, as is done currently?

5. Should it include an explanation as to why the Panel disagrees with the conclusions of the other doctors who have provided opinions on the claim with a view to providing these other doctors with feedback as to why the Panel has disagreed with their medical conclusions?

6. Should the narrative report be disclosed to the worker with the Certificate? Who else should receive the narrative report, eg. interacting groups? (See XII – MRP Interrelationships.) Should S.61 of the Act then be amended? Are there Access to Information/ Privacy consideration?

## IX. MRP CONDUCT

1. Should there be guidelines as to the format of procedures involved in the conduct of a MRP by the Panel?

2. Are Chairmen aware of colleagues' procedures?

3. Can the Chairman of a MRP recommend? Decide? Is a second Panel required, i.e., as an alternative to seeking an opinion from a specialist in another field? What are the guidelines for coordination of IX-3, 4?

4. Should representatives be allowed at MRP proceedings? Under what circumstances? What role should they play?

5. Who settles impropriety matters?

6. Should the Panel further investigate a claim, eg. should the Panel visit the work site to familiarize themselves with the worker's activity in question if they consider this necessary? Is there a distinction between "finders of fact" and "finders of medical fact"?

7. To what extent can the Panel accept the evidence of the worker where it is different from that contained in II – The Statement of Foundational Non-medical Facts? (See also II-1,2,3.)

8. Are delays in the outcome of the claim due to MRP process inefficiencies at (8.1 - 8.8) and how can those delays be eliminated?

    8.1 Determining whether the statutory requirements for an appeal (eg. time limits, bona fide medical dispute, etc.) have been complied with?

    8.2 Preparing the file to go to the Panels?

    8.3 Scheduling the examination?

    8.4 Arranging for diagnostic tests, consultations, etc.?

    8.5 Examining the worker and discussing the findings of the claimant?

    8.6 Drafting the Certificate and narrative and reaching final agreement on the issues?

    8.7 Board follow-up questions to the Panel on clarifications?

    8.8 Disputes by the worker, employer, or a representative, with respect to the interpretation and implementation of the Certificate?

## X. MRP QUALITY ASSURANCE

1. Should there be a quality monitoring process? For Chairmen? For Specialist Members?

2. What form should this take?

3. Who should do the monitoring of the Chairmen?
    - Registrar?
    - BCMA?
    - College of Physicians and Surgeons of B.C.?
    - The Chairmen?

Who should do the monitoring of the Specialists?

Chairmen?
Registrar?
College of Physicians and Surgeons of B.C.?
BCMA?
Specialists?

Others?

4. Should training/educational guidelines be developed for Chairmen/Specialist Members?

5. Should a quality assurance program be in place for the MRP Department?

## XI. MRP CERTIFICATE IMPLEMENTATION

1. What are reasons for delay and how can they be minimized?

2. What are the consequences of Dispute Resolutions Appeals processes?

3. Should the Panel Chairmen be advised as to the compensation decision made on a claim after the Certificate has been implemented, to ensure that the intention of the Panel has been carried out?

4. If a Chairman considers that the intention of the Panel has not been carried out, what should be done?

## XII. INTER-RELATIONSHIPS WITH GROUPS AND REPRESENTATIVES

Groups and Representatives to include Worker, Employer, Workers' Advisors, Employers' Advisors, Legal and Union Representatives, Ombudsman's Office, WCB Advisory Group, The Community, Appeal Division, Review Board, President WCB, Compensation Services Division (including Managerial Review), Medical Services Division, Occupational Safety and Health (Occupational Health Department)

1. Is feedback/interplay adequate with each of these groups?

2. How can the need for MRP appeals be reduced – e.g. how important is failure to medically examine the worker by the Board? Are Compensation Services assessments adequate?

## XIII. REGISTRAR, MRP

1. To what extent should the MRP process be independent of the Board? (should the process be: a) completely external; b) partly external – e.g. with the Registrar (or other individual) reporting to the Governors, as does the Chief Appeal Commissioner?; or c) a different option?

2. Is there a continuing need for a Registrar, MRP?

3. Should the Registrar be an MD or not?

4. What should be the terms of reference/function of the Registrar with particular reference to authority or jurisdiction?

5. Qualifications required?

6. Should the appointment be full-time or part-time?

7. Should the appointment have a term? Renewable?

8. Should the Registrar be a WCB employee or contracted on a consultative basis?

## XIV. MRP ADMINISTRATION

1. Are Chairmen and Specialists compensated adequately? (See also VI-4.)

2. Are there enough Medical Appeals Officers (MAOs)?

3. Are there enough Appeals Clerks?

4. Is the secretarial/clerk staffing adequate?

5. Is office technology up to par?

6. Are resources adequate to provide meaningful statistical analysis and research activity (e.g., Chronic Pain Syndrome impact on MRP functions)?

7. Having accepted that a Bona Fide Medical Dispute has been defined, where the worker is living outside the province, should the Board pay for the whole journey in advance in every case? What should the Departmental Guidelines be on this?

8. Are there delays due to insufficient resources being applied to the processing of MRP appeals? Are there sufficient administrative resources? Are there sufficient MRP resources?

9. Should there be resources made available for legal counsel to the Registrar?

10. Should there be an Annual Report? If so, should it be public? Who should prepare/be responsible for this report?

11. Should there be a permanent manager position for the MRP process?

### XV. AMENDMENTS TO THE ACT

1. What amendments are required to Sections 58 - 66 of the Act?

## 4.2 THE RECOMMENDATIONS

The Recommendations arise from answers to the questions that were posed in Issues, Section 4.1 (see foregoing).

For ease of reader correlation, the headings, subheadings and numbering used in this section are identical to those in Section 4.1.

There are 131 recommendations for consideration. The majority of these could be introduced relatively easily and quickly, while others would require consultation and negotiation. Some of the recommendations would also require amendments to the Act.

### I. INITIATING A MEDICAL REVIEW PANEL APPEAL

#### Appellant's Request

1. The criteria for an appellant's request are clearly stated. The Appeal pamphlet clearly outlines the requirements to proceed to a Medical Review Panel. This pamphlet should be enclosed with a Board decision. Also, the instructions the Department provides with the appeal forms to the appellant upon receiving any notice of intent to appeal are clearly stated. (Appendix 9.2)

#### Time Limits

2. Although the time factors for initiating a Medical Review Panel appeal are relevant, they can, on occasion, be too restrictive. There are extenuating circumstances in which the 90-day time limit under Section 58(3) should be waived.

   The opportunity to establish an appeal in the MRP process should not be lost on a technicality beyond the appellant's control (see also I-3).

3. Guidelines should be developed for extenuating circumstances. The authority for extending time limits should be assigned to the Medical Appeals Officer (MAO). Examples of extenuating circumstances are:
    (i) Worker was informed that his/her representative was handling the matter, only to learn later that the appeal was not forwarded within the time restrictions.
    (ii) Worker was on an extended holiday overseas and returned home to find a Board decision. Although aggrieved by this decision, it was well outside the time requirements to proceed to an appeal to an MRP.
    (iii) Worker was not mentally or physically able to complete the forms, i.e. serious illness, death of a close family member, etc.

    Perhaps the current substantial compliance policy (as set out in item 103.13 of the *Rehabilitation Services & Claims Manual*) should be revised. The revision could make it administratively easier to deal with appeals where only one of the documents has been received within the first 90 days, or if a further Certificate or letter of clarification from the physician is required. One alternative would be to make amendments to Section 58(3)(4), giving the MAOs the authority to allow for a time extension in these cases. (See also Section 4.3 - Amendments to the Act.)

    The authority to grant an extension of time is best exercised by a Medical Appeals Officer (MAO). When reviewing a request for appeal, the MAO ensures that there is a medical question to be resolved and is familiar with the time requirements, etc.

    The MAO could request that the appellant provide his/her reasons for the delay, in writing, and allow the other party an opportunity to respond to the request for an extension of time. The MAO could base the decision on the reasons provided. This would allow consistency and avoid unnecessary reviewing of the appeal.

    Also, a decision by an MAO to reject a request for an extension of time should be appealable to the Workers' Compensation Review Board.

### Physician's Enabling Certificate Establishing a Bona Fide Medical Dispute

4. A clear, concise definition and guideline statement should specify what constitutes a bona fide medical dispute. This should be incorporated with appropriate instructions and guidelines in Recommendation I-5. This would assist in reducing delays at this stage.

5. The guidelines to physicians on instructions regarding defining a bona fide medical dispute (Appendix 9) should be updated, specified and clarified in concise, meaningful fashion. (See I-8,13.)

    The Instruction Sheet provided to a physician is a general and informative outline to complete a medical Certificate to support the appellant's appeal. If the physician has not provided sufficient particulars, the MAOs assist the physicians in defining a dispute by explaining the medical decision and what necessary information could be included in a further Certificate or letter of clarification, to meet the requirement to proceed.

6. The Board should be able to reject an Enabling Certificate on the grounds that time has run out (no acceptable extenuating circumstances) and that a medical dispute is not defined.

   The following are examples of when it would be appropriate to reject an Enabling Certificate:

   (i) If the physician has provided the worker's opinion, not his/her own;
   (ii) Where there is a difference of facts - for example, if the physician has referred to facts that are contrary to those that have been accepted by the Board. It should be noted that if the Board accepted the facts as presented by the physician, it might have reached a different medical conclusion and an appeal to a Medical Review Panel might not have been initiated.
   (iii) If the physician's opinion is expressed as a possibility. It must be clearly stated that the physician is of the opinion that it is more than 50% probable. If the Board felt it was probable, Section 99 would have been applied. (See also I-9.)
   (iv) If the physician's Certificate is received at the Board outside of the time requirements allowed under the Act.
   (v) The decision is not a medical decision that may be appealed to a Medical Review Panel.
   (vi) Insufficient particulars have been provided; clarification is required, i.e. physician addressing a medical issue which was not dealt with by the decision-maker, unclear reasoning, etc.

7. Non-physician, health-care givers should not be able to raise an Enabling Certificate, as their medical knowledge would not be broadly based.

8. The criteria for accepting an Enabling Certificate from an out-of-province physician should be the same as for a physician practicing within B.C. If necessary, the Workers Compensation Act should be amended to enable this to occur. The present policy requirement that a party must show or attempt to obtain a Certificate from a B.C. physician should be eliminated.

   A worker should not be penalized for living in another province (or moving to seek gainful employment). Also, a worker may normally reside in another province and only be on a temporary job situation in B.C. when the injury occurs.

   An out-of-province physician should be registered under the Medical Practitioners Act in his/her province (Canada) or the physician should have a standing, in his/her own jurisdiction, analogous to that of a physician registered in B.C.

9. The criteria for the acceptance of a physician's Certificate from an employer should not be different from the criteria for acceptance from a worker.

   The employer's physician could review the medical records and decisions on the worker's file via disclosure records and state his/her opinion in the terms of probability. This would satisfy the requirements of Section 58(3) and would not appear as lenient as Section 58(4) as it now stands. (Bill 50, Freedom of Information/Privacy legislation may impact on employer disclosure.)

   It should be noted that the worker's physician providing a Certificate does not always examine the worker, just the medical records available.

## Administrative Decision-making

10. The major causes for delays are increased volume and complexity of cases, with no increase in personnel. (See also I-11.)

11. Many delays could be eliminated by an increase in MAO positions. There should be two additional positions developed.

    The MAOs are now reviewing the appeals for further medical information, sending out nominations and statements. This was previously done by Appeals Officers. Consequently, it takes a longer period of time for the MAO to deal with the appeal than before. However, it is generally felt that all of the steps currently taken in the process are necessary to provide a quality final and binding Certificate.

    Analysis of all time frames in the process (Figure 3) to determine areas of inefficiency should be undertaken.

12. In the absence of a statutory amendment, the MAO should make the determination as to whether an out-of-province physician's Certificate will be accepted, applying the guidelines as outlined in Recommendations I-4,5,8,13.

13. The MAO should be responsible for deciding whether a bona fide medical dispute has been established (see also Recommendations I-4,5,8 that clarify and state that "the sufficient particulars to define the question in issue" should be established).

    The MAOs review the file initially to determine if a medical decision has been made, and specifically to determine what that decision is. They have received the necessary training to recognize if the physician has disputed the medical decision on the file.

    "Sufficient particulars to define the question in issue" means that the physician has correctly identified the medical decision.

14. The training program for new MAOs should be more formalized. A training manual should be developed by the manager and MAO current staff. Funding and opportunities should be made available for new and updating courses. The Registrar and Manager of the Medical Review Panels should oversee this activity.

    Some examples of ongoing education would be:

    The Medical Lecture Series offered through Medical Services Division on a monthly basis
    "Evidence or Fact" – legal training
    Monthly adjudication services training – introducing new policy and procedures, etc.
    Participation in future MRP Chairmen's Education days.

# II. STATEMENT OF FOUNDATIONAL NON-MEDICAL FACTS AND ISSUES

## Non-medical Facts

1. The Medical Review Panel should be bound by the Board's findings of non-medical facts, since an opportunity to dispute these findings was available to the worker and employer or their representatives prior to the non-medical facts being finalized by the MAO for the Panel.

   If a different set of facts had existed, the original decision-maker might have reached a different medical conclusion. If the Panel finds a difference of opinion, it should refer the matter back to the MAO for determination of any questionable, non-medical facts.

   The MAO is in the best position to investigate new facts and reach a decision. It is current practice to investigate new evidence and determine facts in the preparation of the Statement. In some cases this involves sending the file back to the Compensation Services Division for clarification, etc. The normal appeal rights would apply to the MAO's determination.

2. In the event that "new non-medical facts" or "disputed non-medical facts" emerge during the examination (history-taking/physical examination) by the Panel, the Chairman of the Panel should consult with the MAO on the case and the Registrar in order to review and resolve the issue.

   Any "disputed" facts should be resolved prior to the Panel examination. All parties should have the opportunity to respond to the Statement and resolve any disputes before the Panel examination takes place. The Panel should base its conclusions on the facts as presented in the Statement. If the Panel questions the facts, it should refer the matter back to the MAO. If a dispute is not resolved regarding the facts, the MAO's decision is appealable to the Review Board.

3. The MAO should be responsible for reviewing the file to obtain any additional medical records that might be relevant to the decision in dispute and are not found on the claim file.

   The MAO has reviewed and is familiar with the entire claim file while preparing the Statement of Foundational Non-medical Facts and is familiar with the general medical history. The MAO is thus aware that, for example, a worker has been seen by a physician for a longer period than shown on the claim file, which usually occurs between the time benefits were terminated and an appeal process is initiated and finalized. However, the review process is time-consuming, resulting in a reduced number of appeals being handled by the MAO.

4. It is acceptable that the Panel Chairman continue to be provided with the "split file".

   A "split file" contains all relevant documents for the Panel's review. To provide the whole file in every case would result in unnecessary paper mass and irrelevant correspondence that does not affect the medical issue before the Panel and would delay the Panel's review of the matter. The MAO may deem that other information is relevant and forward this to the Panel. Of course, the Panel should be able to request the whole file, if felt necessary. Some information not sent to the Panel could or may be considered an opportunity to pre-judge.

Particular care must be taken with respect to claims on which a previous Panel's Certificate has been declared null and void. In such cases, the documents sent to the new Panel must be closely scrutinized to ensure that they do not provide an opportunity for a real apprehension of bias.

5. In order to focus on the facts and issues in an accurate, efficient, organized, and consistent manner, it is necessary for the Board to continue to prepare a Statement of Foundational Non-medical Facts/Issues in every case. It provides a non-medical background and gives the Panel an outline of the facts that led to the issue being appealed.

## Issues

6. The guidelines for preparation of the issues should continue as currently prepared, as they are adequate (see also Section 61 of the Act). They should be reviewed, however, for more flexibility. It should be stated more clearly in the Act that there is authority to ask these questions.

7. For purposes of focus, organization, accuracy and efficiency, the Board should continue to prepare a Statement of Issues in every case. The standard questions should be asked in every case and fairly reflect the issues by being more specific and relevant to the issues raised. (See also II-5.)

   There are times when a Panel exceeds its jurisdiction. This is infrequent, but could increase if no questions were posed. If a Statement was not prepared, this would cause numerous problems in implementing the Panel Certificate (i.e. where the Panel certifies non-medical issues). Also, there may be a substantial increase in the number of clarification requests and perhaps more null and void Panel Certificates, requiring a second Panel.

   Currently, the questions posed cover all situations and leave no doubt as to the medical question to be determined by the Panel. Section 61(1) could be amended to specifically add the authority to enquire about "pre-existing condition and/or disability". (See also Section 4.3 - Amendments to the Act.)

8. There should be a review, with appropriate protection of the worker's entitlement to compensation, with respect to decisions under Section 39(1)(e) (Manual #103.11 F). This would allow the Board to relieve employers of the costs of a claim where a portion of the disability has resulted from an enhancement produced by a pre-existing disease, condition or disability.

# III. DESIGNATION OF SPECIALTY

1. The Registrar should continue to designate the specialty of the MRP, as long as the Registrar is a physician. The worker and employer should continue to have the choice of the Specialists on the Panel but should not be involved in the designation process. This process requires a significant medical judgement assessment of the entire file of the case. The appeal opportunities on this designation should remain. There should be a short biographical note available on every Specialist in order that a worker or employer or the representatives might have some background of the Specialists available, if they wish.

2. In the event that the issues in dispute do not clearly lie in one specialty only, there should be "dual" Panels held where expertise in the different specialties might be required, coordinated by the same Chairman. The Panel should be encouraged to seek any additional appropriate consultation from experts in the field if they so wish. (See also Recommendation IX-3.)

3. As soon as the province of British Columbia has adequate numbers of Royal College Certified Occupational Health Specialists, the joint medical committee should useful particularly for claims for repetitive strain injuries, exposure to toxic substances or other injuries with disabilities that fall under this heading.

4. Medical Review Panels should be encouraged to make more use of outside resources and consult with Specialists in other areas of medicine or other non-medical fields, such as psychologists and epidemiologists. (See also Recommendation V-6.)

5. There should be a review of a number of special common medical syndromes such as Chronic Pain Syndrome (CPS), post traumatic stress and psychogenic stress post-trauma, as they relate to the MRP process. Particular reference should be made to appropriate designated Specialists and coordination of a common ground and medical knowledge (see also Recommendation III-6). In the context of the MRP process, the Registrar, MRP should act a contributor to this type of activity and information distribution.

6. There is a need for a common information and knowledge base for chronic pain, Chronic Pain Syndrome and post-traumatic psychogenic stress. A physician document should be developed that would assist in mutual decision-making for the MRP, the WCB, the worker, the employer and the representative. The Registrar, MRP, should act as a contributor to this type of activity and information distribution. (See also Recommendation III-5.)

## IV. APPOINTMENT OF CHAIRMEN, MRP

1. In keeping with current trends and terminology, the term should be changed to Chair.

2. The appointment of Chairmen should continue to be made by the Lieutenant-Governor-in-Council (Order-in-Council appointment). It is important to maintain the independent, non-political nature of the appointment. There is a quasi-judicial aspect to the appointment. This arrangement carries the connotation of a special status, which is appropriate. The Lieutenant-Governor-in-Council should consult with the Board of Governors prior to making appointments. The Board of Governors should consult with the Joint Medical Committee prior to giving their advice.

3. The combined special medical committee of the College of Physicians and Surgeons of B.C. and the British Columbia Medical Association (BCMA), which currently creates lists of Specialists, should continue to be the recommended committee on Specialist Members (see also V). [Note that the Act only refers to a "Medical Committee" (S. 58(2)) in relation to the Specialists (Appendix 5).] Consideration should be given to the Dean of the Faculty of Medicine of the University of British Columbia (or designate), to be included as a member of the special committee. (See also V - Appointment of Specialist Members, MRP.)

4. Currently, appointments of Chairmen are without term. Chairmen should be appointed for a five-year term, renewable and subject to review. Criteria for re-appointment should be developed by the Registrar and approved by the Board of Governors, Joint Medical Committee and Chairmen, MRP, prior to final approval by the Lieutenant-Governor-in-Council.

5. There should be a termination process for Chairmen, MRP. Guidelines for this procedure should be developed by the Registrar, MRP and supported and approved by the Joint Medical Committee, Chairmen, MRP and the Board of Governors, prior to final approval by the Lieutenant-Governor-in-Council.

6. A formal, stated list of qualifications should be made available for a Chairman's position by the Joint Medical Committee. In addition, a job description, guidelines of duties and functions should be clearly stated by the Joint Medical Committee and made available to the Registrar and Chairmen for their input and approval. The Registrar, MRP would coordinate and recommend the statement to the Board of Governors for final approval.

7. Specific educational programs should be developed for new appointments and continuing appointments to include a curriculum of subjects that would be covered. This should be developed by the Registrar in consultation with the Chairmen. This process has begun.

8. Activities such as conduct of Panels, drafting of Certificates and Narratives should be monitored for quality on as objective a basis as possible, built upon criteria developed by the Registrar, in consultation with the Chairmen. The intent and objectives are for facilitation and improvement, not legislation.

9. The community should be kept informed about the process of appointing Chairmen and be assured as to the fairness of this process with regard to securing the best possible physicians without bias. Consideration of region/gender should be part of this process.

10. Panel Chairmen should be required to have some knowledge of occupational medicine or industrial worksites, but not necessarily have the specialty certification in this specialty.

11. A process should be established for receiving complaints with respect to Medical Review Panel Chairmen. For example, complaints from Specialists with respect to certain Panel Chairmen or complaints from workers with respect to their examinations by a certain Medical Review Panel (see also V – Appointments of Specialist Members, IX – MRP Conduct and X – Quality Assurance Programs). This information would be confidentially coordinated by the Registrar, MRP. A special Quality Assurance Committee of three Chairmen (chosen by the Chairmen themselves) would be advisory to the Registrar, who would chair this committee.

12. Any of the currently appointed Chairmen should be able to serve as an acting Chairman when a Chairman is unable to continue to act in a particular case e.g. death of a Chairman. This would require an amendment to Section 58(1) of the Act.

## V. APPOINTMENT OF SPECIALIST MEMBERS, MRP

1. The current practice of the appointment of Specialists to the MRP list by the Joint Medical Committee of the College of Physicians and Surgeons of B.C. and the BCMA (s. 58(2)) is appropriate to continue. The committee should be expanded to include the Dean of the Faculty of Medicine, University of British Columbia or designate. The committee should be receptive to recommendations from the Chairmen, coordinated by the Registrar, MRP. (See also Recommendation V-2.)

2. The current practice of the "medical committee members" being selected by the nature of their position is satisfactory. This committee is thus composed of the Registrar, College of Physicians and Surgeons of B.C., the Executive Director of the BCMA, and the Assistant Executive Director of the BCMA (who acts as Chairman). The committee should be expanded to include the Dean of the Faculty of Medicine (or designate) and to include a member at large, both from the College and the BCMA.

3. There needs to be a constant updating of the list of available Specialist Members for the MRP. The number of selected Specialist Members in a given specialty is not always adequate. Constant updating would reduce any delays due to scheduling of available Specialists.

4. The guidelines and criteria used by the Joint Medical Committee for the selection of Specialists for the MRP list should be more formalized and made public to the medical community and community at large.

5. Physicians and surgeons in B.C. should be adequately notified of the opportunity to become a Specialist Member of the MRP. (See also Recommendations V-1,3.)

6. Non-physician health-care givers should not be appointed to Panels. Their medical base of knowledge would be too limited for the medical issues that present to MRP. However, appropriate consultation should be encouraged. (See also III-4.)

7. The current list of disqualifications (see Table 10) for Specialist Members serving on a given Panel is adequate. Other disqualifications should be included as they become apparent from experience. This list should be continually updated. For example, the current list of disqualifications for Specialist Members should include a preclusion for those Specialists who have previously served on a prior MRP involving the worker. Also, a preclusion may be necessary for Specialists who are related to physicians who have previously treated the worker. A Certificate has recently been declared null and void as a result of this relationship.

8. The MAO should make the nomination of a Specialist on behalf of the Board when the worker is self-employed, a partner or member of the firm that is the employer, or where the employer has closed its business in the industry in which the injury or disability occurred. (The Board is to nominate the Specialist as if it were the employer under Section 59(2).)

   The MAO should nominate on behalf of the Board as he/she is more aware of the disqualifications, availability on mutually agreeable dates (with the other nominated Specialist), etc.

9. It is appropriate for the Minister of Labour to nominate on behalf of the worker or employer if there is a failure to nominate a Specialist Member within the eight-day period after receiving notice. But an eight-day period is too restrictive with respect to nominating the Specialists. Perhaps a 21-day period would be more appropriate. (See also Section 4.3 - Amendments to the Act)

10. Delays in the process have been identified due to Specialists' unavailability. The specialties in which this occurs should be identified on an ongoing basis and in consultation with the medical committee, and rectified as soon as possible by additional Specialists being named. The Registrar should be responsible for seeing that this is done. (See also Recommendation V-9.)

11. The Specialist lists should be updated on a regular basis (see also Recommendation V-10). The medical committee should meet on a regular basis and maintain the listing of specialty members at an adequate level, as advised by the Registrar.

## VI. EDUCATION/TRAINING OF CHAIRMEN, SPECIALIST MEMBERS AND MRP DEPARTMENT STAFF

1. Current orientation (see Appendix 10.1 and 10.2) for new Chairmen and Specialist members is not entirely adequate (see also V – Appointments). This should be updated and expanded in an appropriate manner. The Registrar should be responsible for developing and coordinating this in consultation with the Chairmen.

2. The WCB should continually improve continuing education and training for MRP Chairmen and Panel Specialist Members, making available to them information regarding relevant compensation issues, terminology, role, jurisdiction of MRPs and any relevant issues. The Registrar should coordinate this.

3. Educational and procedural sessions for Chairmen and relevant Specialist Members should be combined. Other interested parties should be invited, e.g. MRP Department members, legal counsel, Compensation Services personnel.

4. There should be funding support to Chairmen, Specialist Members and MRP Department staff for attendance at training/educational sessions. This should be a recognized budget item for the MRP Department. (See also XIV-1.)

5. There should be a process for bringing together, from time to time, the MRP Chairmen to discuss common issues. This should be done at least every six months. Staff members of the MRP Department should attend these sessions.

6. There should be a process for advising the MRP Chairmen as to the implementation results of their own Panel and of the examinations of other MRPs. The Chairmen should be kept generally informed of the decisions of other Panels. This should be coordinated by and be the responsibility of the Registrar, MRP.

7. The MRP Chairmen should be provided with copies of Court decisions and Appeal Division decisions issued with respect to the MRP process on an ongoing basis.

## VII. MRP CERTIFICATE

1. There should be guidelines for a format of the MRP Certificate. They should be developed by the Registrar in consultation with the Chairmen, MRP. It is important that these be seen as facilitatory, rather than legislative.

2. There should be monitoring of the quality of the Certificate. Guidelines as to an acceptable standard should be developed by the Registrar, in consultation with the Chairmen. (See also X.)

3. As part of the MRP Certificate, reasons should be given for the decision. The reasons should be stated clearly and concisely and be included in the Certificate and not in the narrative, as the Certificate is the binding document. (See also Recommendation VIII-4.)

   The reasons should be separated from the conclusions (answers to the issues raised) in the Certificate and appear at the end of the Issues #1 to #10. The reasons would not be binding under Sec. 65.

4. There should be suggested time limits, as a guideline only, for Panels issuing Certificates. A six-week time limit would seem reasonable.

5. Ideally, the need for clarification of Certificates should be eliminated by an improvement in the quality of a Certificate, e.g. no ambiguity, no contradictions, no inconsistencies, not beyond the Panel's jurisdiction, no errors made, and no new consideration of new non-medical factual evidence (See also Recommendations VII-1,2,3,6,11,12 and Appendix 11.)

   Processes for managing a need for clarification and reconvening should be developed. They are currently in transition. There should be criteria and guidelines as to when clarification should be sought (See also Recommendation VII-6.)

   New issues, but in continuance and incidental to the related issues – i.e., consequential matters – should be included in this process.

6. Problems with the Board's adjudicator interpretation and implementation of Certificates should be referred to a specialized process within the Compensation Services Division (see also Appendix 11). Any resultant request for Panel clarification, reconsideration, reconvening or a null and void ruling would be referred back to the Registrar, prior to going to any given Panel (see also Recommendations VII-5,12).

   There should be statutory provisions for this recommendation. (See also Amendments - Section 4.3.)

7. There should be no differences in process (see also Recommendation VII-6), between the adjudicator requiring clarification to implement the Certificate and afterwards, when an external party asks for clarification because they dispute the implementation.

8. Feedback (for example to MRP, WCB Medical Services) should be more effective than is currently the case. Feedback should incorporate how each Certificate has been "interpreted" and "implemented". Feedback should be relevant to the area receiving the information. The feedback may, for example, be different for the MRP and for the WCB Medical Services.

9. The Board should continue to have the authority to declare a Certificate "null and void" – to declare a Certificate beyond the jurisdiction of the Panel. The criteria to do so are basically that the Panel Certificate has erred or gone beyond its jurisdiction/authority (see also Appendix 5 - the Act (Section 59(1)), the *Rehabilitation Services & Claims Manual* in Appendices 5 and 9, and also discussion under The Statement of Non-medical Facts and the Issues, pages 58-59). It would be beneficial to have legal representation available to the Registrar and MAOs to review these matters.

10. The current distribution (to the worker, employer, and enabling physician) of the Certificate is adequate.

    Findings sent to the employer should be clearly marked "confidential". Many large firms have mailrooms where the mail is opened and sorted prior to the department distribution.

11. Criteria for requesting reconvening of an MRP should be published (see also Recommendation 5). If the criteria are met, but the MRP cannot be reconvened because of the death of a Chairman or Specialist Member of the Panel, a new Panel should be constituted.

12. If new evidence arises after an MRP Certificate has been issued, the Panel should reconvene. Criteria of what constitutes "new evidence" should be clearly defined. Background information to the subject of evidence may be found helpful in Section 2.1 – Administrative, Policy and Procedural Functions. The special process outlined in Recommendations VII-5,6 determines whether the new evidence is valid or not in association with the review by the Medical Appeals Officer and the Registrar, MRP.

    Under 103.58 of the *Manual*, an MRP can reconvene or a new Panel be formed if new evidence is received that shows a fundamental medical mistake has been made. A new Panel would not be recommended simply on the basis of a new medical opinion.

13. New evidence should impact on the binding nature of the Certificate only if the Panel alters or modifies its decision as a result of the "new evidence factor".

14. An MRP Certificate should not be referred back to the Panel for clarification before a claims decision is made when the Certificate is disputed by the appellant's physician. The Certificate is not open to question or review.

15. With respect to how long an MRP Certificate is valid, MRP Certificates are a final decision for that given medical issue under dispute and thus remain valid indefinitely unless new evidence persuades the Panel differently. If new issues arise, then a new Panel should be constituted and that becomes the basis for a new Certificate. It does not necessarily invalidate the previous Certificate, but it may have an impact on it. (see also Recommendation VII-13)

    Section 65 of the Act (Appendix 5) states, "A Certificate of a Panel is conclusive as to the matters certified and is binding on the Board. The Certificate is not open to question or review in any court, and no proceedings by or before the Panel shall be restrained by injunction, prohibition or other process or proceeding in any court or be removable by certiorari or otherwise in any court."

    The validity of a Certificate is timeless. Any subsequent decision of the Board, at any point in time, must be consistent with the Certificate.

16. The Chairmen/Registrar, MRP should have access to independent legal counsel when it is felt that the Board is usurping jurisdiction of the Panel or when there is disagreement with the Board in matters of Law.

## VIII. MRP NARRATIVE REPORT

1. The purpose of the Narrative Report should be more clearly defined. Guidelines for the format of the Narrative should be developed by the Registrar, in consultation with the Chairmen, in order to ensure consistency and completeness. It is important that this guidance be seen not as legislation, but as facilitation.

2. Procedures for clarification of contradictions with the Certificate should follow the process outlined in Recommendation VII-5,6.

3. The Narrative Report should be required in association with the Certificate. The Act does not specify that a Narrative Report is legally binding. In fact, the Act does not state that a Narrative Report is required from the Panel.

4. The Narrative Report should not be used to provide the reasons for the Panel's decision. The reasons should be included in the Certificate, as it is the binding document (see also Recommendation VII-3).

5. The Narrative Report should not include an explanation as to why the Panel disagrees with the conclusions of other doctors who have provided opinions on the claim. The inclusion of reasons for the decision, as recommended in VII-3 and VIII-4, would provide these other doctors with feedback as to why the Panel has disagreed with their medical conclusions.

6. There should be continued discretion in distribution of the Narrative Report in view of possible personal and sensitive medical information being present in the report. Compliance with Bill 50 – Freedom of Information and Protection of Privacy Act should be undertaken.[32]

## IX. MRP CONDUCT

1. There should be guidelines for the Chairmen and Specialist Members as to the format of procedures involved in the conduct of an MRP. These guidelines should also be published in the form of a public brochure (perhaps with modification) so that the appellant may have a prior understanding of the examination process. The Registrar should develop this in consultation with the Chairmen and Specialist Members.

2. The Chairmen should be made aware of colleagues' procedures. This process began during the Chairman's Education Day, May 29, 1992. It should be ongoing.

3. The Chairman of an MRP, in consultation with the Registrar, should be able to recommend to the Registrar that a second Panel is required, as an alternative to seeking an opinion from a Specialist in another field (see also Recommendation III-2). The same Chairman should coordinate the two Panels.

4. Representatives and other individuals should be allowed at MRP proceedings under certain circumstances, particularly when an interpreter is required or in the event that the MRP is being held on a fatality issue. Written submissions to the Panel should be encouraged, if necessary. Copies should be sent to the worker and employer, preferably prior to the Panel being held. A representative would not stay during the physical examination of the appellant.

5. The College of Physicians and Surgeons of British Columbia should settle impropriety matters, in consultation with the Registrar.

6. Under appropriate circumstances, the Panel should have the opportunity to further investigate a claim. The Panel might wish to visit the worksite to familiarize itself with the worker's activity in question if it considers this necessary, keeping in mind that there is a distinction between "finders of fact" and "finders of medical fact" and that the Panel is bound by the Foundational Statement of Non-medical Facts.

7. The Panel cannot accept the evidence of the worker where it is different than that contained in the Statement of Foundational Non-medical Facts, pages 58-59 (see also Recommendation II-1,3). However, this should not apply to medical facts ascertained in the history taken during the Panel examination. However, if there is any doubt, the Panel Chairman should contact the MAO to discuss.

8. Recent statistical data has identified duration of time (in days) for each phase of the Medical Review Panel process (see Figure 3 and Recommendations 8.1 to 8.8). An analysis should be conducted of the areas listed below to identify the factors that may contribute to delay and improve the efficiency of the process.

    8.1 Determining whether the statutory requirements for an appeal – for example, time limits, bona fide medical dispute, etc. – have been complied with.

    8.2 Preparing the file to go to the Panels.

    8.3 Scheduling the examination.

    8.4 Arranging for diagnostic tests, consultations, etc.

    8.5 Examining the worker and discussing the findings of the appellant.

    8.6 Drafting the Certificate and Narrative Report and reaching final agreement on the issues.

    8.7 Board follow-up questions to the Panel on clarifications.

    8.8 Dispute by the worker, employer or representative with respect to the interpretation and implementation of the Certificate.

# X. MRP QUALITY ASSURANCE

1. There should be a quality monitoring process for performance of Chairmen and Specialist Members.

2. It should take the form of a set of standards expected of the Chairmen and Specialist Members in the performance of their duties and functions on an MRP. The standards should be set by an advisory committee of Chairmen and Specialist Members and reported to the Registrar, who would coordinate this activity (see also X-3).

3. The monitoring would be done by an advisory committee on quality assurance, composed of three Chairmen elected by their Chair colleagues. The Registrar would act as Coordinator and Chairman of the committee (see also X-2). The Quality Assurance Committee would also monitor the Specialist Members' performance. The committee would meet on a regular basis.

4. Training/educational guidelines should be developed for Chairmen and Specialist Members. These should be coordinated by the Registrar, in consultation with the Chairmen and Specialist Members.

5. A quality assurance program should be in place for the MRP Department. The MRP Manager and Registrar should oversee this.

# XI. MRP CERTIFICATE IMPLEMENTATION

1. The reasons for delay in MRP Certification implementation should be identified and measures taken to minimize the factors leading to delays. (For a proposed mechanism and process see also Recommendations VII-4,5,6.)

2. Dispute resolution processes should be managed as efficiently and quickly as possible in order to reduce lengthy and costly delays in the implementation of the MRP Certificate.

3. The Panel Chairman, through the Registrar and Manager MRP, should be advised as to the Compensation Services decision made on the claim after the Certificate has been implemented to ensure that the intention of the Panel has been carried out (see also VII-8).

4. If a Chairman considers that the intention of the Panel has not been carried out, a request to the Registrar for a review of the issue should be made. The Registrar, deciding that the issue is valid, will consult with the appropriate personnel within the Compensation Services Division. This process would be subject to the normal criteria and procedures regarding clarification and reconvening (see also VII-5).

# XII. INTER-RELATIONSHIPS WITH GROUPS AND REPRESENTATIVES

Although an independent process, the MRP does not function in isolation. There are many useful interactions that are helpful to the resolution of disputes, concerns and issues with the Review Board, a variety of groups and representatives within the community of the WCB, and within the community at large. These are, for instance (within the WCB), the Appeal Division, the President of the WCB, the Compensation Services Division (including managerial review), the Medical Services Division, and the Occupational Safety and Health Division (Occupational Health Department). In the community at large, interactions take place with the worker, the employer, the Workers' Advisors, the Employers' Advisors, representatives from legal and union areas, the Ombudsman's office, the WCB Advocacy Group and the community at large.

1. Feedback/interplay from the MRP Department should be meaningful and relevant when these groups and/or representatives have been active in a case. Updating them should be routine.

2. A review should be undertaken to see what could be done to reduce the need for MRP appeals. For instance, how important is failure to medically examine the worker by the Board? Are Compensation Services assessments of medical issues adequate?

# XIII. REGISTRAR, MRP

1. The MRP process should be and be seen to be independent of the Board as much as possible. It is envisioned that the process might go through several phases of independence. Currently, initial changes have taken place in this direction. For example, the MRP Department is now a separate and distinct department not related to the Appeal Division. The department is geographically separated on site. The Registrar is an independent physician position contracted on a consultative basis, reporting to the Board of Governors. This current status should continue during the implementation of the Report's recommendations.

   A future consideration might review the advantages/disadvantages of having a completely separate entity from the WCB, including a premise separate from the WCB, and incorporating facilities for the MRP examinations within it. The Registrar would then report to the Minister of Labour and Consumer Services.

   Current trends are certainly toward Appeal bodies being independent, but remaining within the system (Board's structure).

2. There is a continuing need for a Registrar (see also XIV-11).

3. The Registrar should be an MD. There are ongoing interactions between the Registrar and the Panel Chair, Specialists and medical associations. This would include such matters as assigning the most appropriate MRP specialties, dealing with improprieties, ensuring that the Specialists lists are adequate, dealing with medical factors involved in the MRP administrative process, etc. As a result, the most appropriate qualification for a Registrar would be that of a physician.

4. There should be terms of reference/function of the Registrar, with particular reference to authority or jurisdiction of the position as in Recommendations III-1,5,6; IV-5,6,8,11; V-1,7,8; VI-1,2,6; VII-1,2,6; VIII-1; IX-1,3,5; X-2,5; XI-4, and as outlined in Appendix 1.

5. The qualifications of a Registrar should be outlined. (See current description, Appendix 1 and Recommendation XIII-4.)

6. At this stage the appointment should be a part-time position, but with greater time than the 1-1/2 days per week currently allocated. Two days per week (or its equivalent) should be minimal. A full-time role could be easily envisioned (see XIII-4) in the not-too-distant future.

7. The appointment should have a five-year term, renewable on review.

8. The Registrar should not be a WCB employee. The Registrar should be contracted, on a consultative basis.

## XIV. MRP ADMINISTRATION

1. The Chairmen and Specialist Members should be compensated adequately. The rate should be at least at a level of office private practice. Currently, in most instances, they fall below this level. Continuance of the settlement reached through negotiation with the BCMA/WCB is appropriate. A review should be undertaken to explore options of reimbursement compensation through channels other than the WCB. The adjustments in accordance with the Board's ratio under Section 25 with regard to the Consumer Price Index should be continued.

2. There are not enough Medical Appeals Officers on staff. There should be two additional positions. Personnel increases have not kept pace with the increased volume of applications and increases in the complexity of the cases presented. During the transition to departmental status, there has been no replacement of the Senior Medical Appeals Officer since the incumbent became Manager, MRP Department.
   The managerial position should be continued and made permanent (see also XIV-11).

3. At this stage, there are enough Medical Appeals Clerks.
   At the present time, it appears that there are enough clerks within the Department. However, with more experience and once all of the workload previously handled by the Appeals Officers is divided, there may be a need for another clerk's position in the future.

4. A secretary and steno clerk/filing position should be obtained. (These are currently being appointed.)

5. Office technology is up to par. The computer equipment is new and adequate. There may be a need to upgrade training to make better use of the software and to streamline mailing lists, etc.

6. Budgetary resources should be adequate to provide, for example, meaningful statistical analysis and research activity, particularly in areas that are common and important in their impact on the process such as the chronic pain syndrome.

7. There should be departmental guidelines for travel reimbursement for the out-of-province worker. Having accepted that a bona fide dispute has been defined where the worker is living outside the province, the Board should pay for the whole journey, in advance. The WCB revised guidelines on this issue (see Appendix 8) should be followed in order to retain consistency throughout the system, providing that it is recognized that there are some times within the MRP process that special circumstances have to be met. The MAOs should have discretionary authority to make decisions in these situations.
   The policy in the *Rehabilitation Services & Claims Manual* should be revised to refer to the flat fee, with no dollar amount attached, which would enable periodic adjustments to this amount.

8. Delays due to insufficient resources and insufficient MAO and support staff (being applied to the processing of MRP appeals), should be corrected as soon as possible, as backlog and the number of applications continue to increase. (see Tables 3 and 4)

9. Resources should be made available for legal counsel to the Registrar.

10. It is recommended that there be an annual public report. The Registrar should prepare/be responsible for this report.

11. The position of Manager should be made permanent. There is an essential need for a Manager, MRP, to handle administrative matters, i.e., preparing budgets, documents, departmental reports and statistics, as well as overseeing staffing requirements, quality control, planning, etc. (see also XIV-2)

# 4.3 PROPOSED AMENDMENTS TO THE ACT

## SECTIONS 58-64

### 1. Board's Authority as to MRP

The Act should state specifically that the Board has authority to administer the MRP Process, including the right to adjudicate requests for a MRP and to pose the issues raised by Section 61. As the MRP process becomes more independent, the need for this amendment would be less.

## SECTION 58

### 2. Time Limits for MRP Appeals

2.1 There is presently no provision to extend the 90-day period for appealing to an MRP. Under extenuating circumstances beyond the control of the appellant, extension should be allowed.

2.2 The point at which the time period commences should be defined more precisely and made consistent with the Review Board and Appeal Division provisions in Sections 90 and 91. Section 58 refers to "clear days", which does not appear in Sections 90 and 91.

## SECTIONS 58,63

### 3. MRP Appeal by Representative

3.1 Section 58(3), Section 58(4) and Section 63(1) do not specifically authorize appeals by a representative of a worker or employer or a dependant. The current practice is to allow appeals to proceed if the notice to proceed is from a representative. The Act should permit a representative of a worker or an employer to: (a) commence an appeal to an MRP on behalf of the worker, dependant or employer; (b) provide the nomination of Specialists on behalf of the worker, dependant or employer.

## SECTION 58

### 4. Employer's Right of Appeal

4.1 Section 58 (4) gives a right of appeal to a "former employer". It is not clear why this is necessary. There is no such provision in Sections 90 and 91.

4.2 Section 58 should provide the same certification standard for employers' physicians as for workers' physicians.

4.3 Unlike Section 58(3), Section 58(4) does not require that an actual Bona Fide Medical Dispute be shown. It is enough that there "may" be such a dispute.

4.4 The Act should permit an organized group of employers to be able to: (a) commence an appeal where the employer is no longer in business; (b) provide the nomination of Specialist where the employer is no longer in business.

5. **Certificate by Out-of-Province Physician**
   5.1 The Certificate to commence an MRP Appeal must be from a "physician" (defined in Section 1 as being a physician registered in B.C.)
   5.2 The Act should permit a Certificate of Bona Fide Medical Dispute to be submitted by an out-of-province physician provided his/her credentials/qualifications are in good standing in the geographical region of practice.

## SECTIONS 63, 60

6. **MRP Fatal Cases**
   6.1 Section 63 only allows a dependant of a deceased worker to appeal in a fatal claim. There is also no time limit on the right of appeal requirement that a physician's Certificate be provided. Appeals to MRPs on fatal cases should be made consistent with MRPs on non-fatal cases – for example, instituting a time limit for appeals, requiring for provisions of Certificate of Bona Fide Medical Dispute, making the right of appeal for an employer.
   6.2 Section 63(2) requires the "last employer" to nominate a Specialist for an MRP dealing with a fatal claim. The last employer of the deceased may not be in an industry that provided exposure alleged to have caused the deceased's death.
   6.3 The Specialists excluded by Section 63(2) are not the same as those excluded by Section 59(1).
   6.4 MRP fatal procedures, Section 63(3), incorporates a number of procedural provisions governing appeals in non-fatal cases, but is incomplete. It does not, for example, incorporate Section 59(2) and 61(3), which it should.
   6.5 Section 60 requires an examination by the Panel, which means that if a worker appeals, but dies before he can be examined, his appeal must be discontinued. The Act should provide for consideration of an MRP appeal on the basis of a file review, rather than on examination, where the worker dies after initiation of the appeal, but before it is processed.

## SECTION 64

7. **Statement of Foundational Non-medical Facts/Issues**
   7.1 It is proposed that the Act specifically require the MRP to follow the Statement of Foundational Non-medical Facts prepared by the Board, i.e.: make non-medical facts binding on MRPs.

## SECTION 61 (1)

   7.2 "Disability" in Section 61(1) should be amended to "Impairment" (each time it occurs).

## SECTION 58 (1)

### 8. Chairmen Appointment

8.1 Section 58(1) should be amended to allow any currently appointed Chairman to be able to serve as an acting Chairman when a Chairman is unable to continue to act in a particular case e.g. death of a Chairman.

## SECTION 58 (2)

8.2 The term "Chairman" should be changed to "Chair".

### 9. Specialists Lists

9.1 Expand this section to include diseases. This section presently requires the compilation of lists of Specialists in "particular classes of injuries and disabilities". It should be amended to include "diseases".

## SECTION 59

### 10. Specialists Nominations

10.1 Section 59(2) requires that the Board rather than the employer nominate the MRP Specialist, where the worker is a principal or partner. Section 59(5) requires the Minister to nominate when the respondent to the appeal fails to nominate. Why the Board in one case and the Minister in the other? The Workers' Advisor or Employers' Advisor should nominate.

10.2 Section 59(1) only allows eight days for a worker or employer to nominate a Specialist to sit on the MRP. This should be amended to 21 days.

10.3 Section 59(1) should be changed to refer to "class of injury or ailment" from "class of injury or disease".

## SECTION 65

### 11. MRP Certificate Authority

11.1 The Act should give the Board specific authority to determine whether an MRP has issued a "proper" Certificate within its jurisdiction, where clarification is required and, in "appropriate" cases, to reconvene MRP or refer the same issue to another MRP. It should provide specifically for situations where a second Certificate is received covering the same questions as the prior Certificate.

## SECTION 61 (2)

### 12. MRP Narrative Report Disclosure

12.1 Regarding MRP Narrative Report disclosure, Section 61(2) provides that the Panel may make a Report and that the Report must be sent to the physician who issued the Enabling Certificate. The worker is given no right to receive a copy. The Board's practice is not to provide a copy except on the appeal as part of the regular disclosure process. The Act should give the worker, dependant and employer the right to receive a copy of the Report.

# SECTION 5

# APPENDICES

# APPENDIX 1

## POSITION DESCRIPTION: REGISTRAR, MEDICAL REVIEW PANELS

### TERM

The appointment will be on a contract basis for a period of one year. It is a part-time position requiring approximately thirty hours per month.

### REPORTING

The Registrar, Medical Review Panels, will report to the Governors through the office of the Chairman, Board of Governors.

### RESPONSIBILITIES

The Registrar, Medical Review Panels, will be responsible for generally overseeing the administration, policy and procedure of the Medical Review Panel process, including:

- reviewing the administrative functions performed in preparation for a Medical Review Panel examination, that is, the determination as to whether a Bona Fide Medical Dispute has been defined, the preparation of the statement of foundational non-medical facts and issues, the preparation of the file and gathering of additional medical evidenced;
- providing advice and assistance to the Medical Appeals Officers in the performance of these administrative functions as required from time to time;
- reviewing all Medical Review Panel Certificates received by the Board with a view to highlighting difficult areas and providing the Board with feedback on cases where the Medical Review Panels are in disagreement with the Board;
- adopting a leadership role among the Medical Review Panel Chairmen with a view to facilitating regular communication between the Medical Review Panel Chairmen;
- establishing a program of orientation, training, ongoing education and communication for the Medical Review Panel Chairmen;
- developing criteria and procedures for the recruitment and selection of new Specialist Members and Medical Review Panel Chairmen;

The Registrar, Medical Review Panels, will be responsible for generally monitoring the performance of the Medical Review Panel system over the term of the contact. At the end of the term, the Registrar will be required to make recommendations to the Governors with respect to the administration, policy and procedures of the Medical Review Panel process.

## QUALIFICATIONS

The Registrar, Medical Review Panels, should be a doctor with several years' experience in the practice of general medicine or any specialty. Legal training or familiarity with basic legal principles would be an asset.

The Registrar must be able to effectively communicate with the Medical Review Panel Chairmen, the Specialist members, Board physicians and community physicians and have a good relationship with all of his or her peers in the medical community. The Registrar must have good interpersonal and administrative skills in order to effectively interact with and advise Board staff involved in the Medical Review Panel process. He or she should have the ability to write clearly and concisely. He or she must be comfortable with both medical and legal issues and understand the role and function of the Medical Review Panel process under the Workers Compensation Act.

## REMUNERATION

To be negotiated.

# APPENDIX 2

## SYNOPSIS
## CURRICULUM VITAE

## REGISTRAR: DR. L.C. JENKINS

PERSONAL:

Married, two children.

PROFESSIONAL POSITIONS:

Professor and Head, Department of Anaesthesia, Faculty of Medicine, UBC. Head, Department of Anaesthesia, Vancouver General Hospital. Director of Respirator Therapy Technology, Cardiovascular Perfusion Technology, Hyperbaric Medicine, Anaesthesia Technology - Nov. 1970 - July 1991. Consulting Physician in Anaesthesia at University Hospital, St. Paul's Hospital, Grace and Children's Hospital of B.C.

| | |
|---|---|
| 1948 | Undergraduate B.A., UBC. Honours in Bacteriology and Preventative Medicine |
| 1952 | M.D., C.M., McGill University, Montreal, P.Q. |
| 1952 - 59 | Resident - UBC |
| 1959 | - FRCPC - in Anaesthesia Royal College of Physicians and Surgeons of Canada<br>- Diplomat American Board of Anesthesiology<br>- California State Medical Board |

ACADEMIC AWARDS AND DISTINCTIONS:

| | |
|---|---|
| 1949 | J.H. Wood Medical Scholarship |
| 1950 - 1952 | B.C. Foundation Scholarship Award in Medicine |
| 1956 - 1957 | Burroughs Welcome Teaching and Research Fellowship, UBC |
| 1958 - 1959 | The R.S. MacLaughlin Traveling Fellowship Britain/Scandinavia/USA (UBC) |
| 1963 | Canadian Oxygen Prize (best original work in anaesthesia in Canada) |
| 1978 | Queen's Silver Jubilee Medal (Community Service) |
| 1982 | St. John's Ambulance - Provincial Recognition Award |
| 1986 | St. John's Ambulance National Recognition Award |
| 1991 | Vancouver General Hospital Special Service Award |
| 1991 | Professor Emeritus, UBC & Honorary Staff, VGH, University Hospital |

| | |
|---|---|
| 1991 | The Dr. L.C. Jenkins Award for Outstanding Scholastic Achievement in the Cardiovascular Perfusion Technology Program (Cariboo/VGH) |
| 1992 | Invested as Serving Brother, The Order of St. John, Privy of Canada |

## PROFESSIONAL ACTIVITIES:

- Fellow, Royal College of Physicians and Surgeons Canada (in Anaesthesia)
- Diplomat American Board of Anesthesiology, in Anesthesiology
- Past Chairman, B.C. Anaesthetics Society
- Past Chairman, Scientific Program Committee, Canadian Anaesthetists' Society
- Past Chairman, Education Committee, Canadian Anaesthetists' Society
- Royal College Examiner - 6 years
- Member, BCMA, CMA, BC College of Physicians and Surgeons
- Past associate editor, International Society of Anaesthesia and Analgesia, Current Researches
- Past associate editor, Japanese Journal of Anaesthesia Review
- Past Chairman, Specialty Committee, in anaesthesia, Royal College of Physicians and Surgeons of Canada
- Past Chairman, Association Canadian University Departments of Anaesthesia (ACUDA)

## PUBLICATIONS AND RESEARCH:

| | | |
|---|---|---|
| Peer reviewed original journal publications | - | 107 |
| Medical text books | - | 3 |
| Research grants | - | 36 |
| Visiting professorships and Scientific paper presentations | - | 92 |

## NON-MEDICAL INTERESTS:

Nature and environmental societies, horses, cows, farming, cross-country skiing, fly-fishing, music, literature.

# APPENDIX 3

## CURRENT MRP CHAIRMEN

Dr Darryl G. Morris
Vancouver BC

Dr Geoffrey L. Nanson
Vancouver BC

Dr Robert S. Purkis
Vancouver BC

Dr J. Trevor Sandy
Vancouver BC

Dr John P. Sloan
Vancouver BC

Dr John Sanderson Smith
Vancouver BC

Dr Stanley L. Sunshine
Vancouver BC

Dr Peter Allan
Vancouver BC

Dr Peter J. Banks
Victoria BC

Dr Beverley G. Barron
Vancouver BC

Dr Nigel H. Clark
Vancouver BC

Dr Ian D. Connell
Vancouver BC

Dr Victor Dirnfeld
Richmond BC

Dr R. Cameron Harrison
Vancouver BC

# SUMMARIZED BIOGRAPHICAL NOTES OF CURRENT CHAIRMEN

## MEDICAL REVIEW PANEL

**Dr. Nigel H. Clark**

| | *Professional Education* |
|---|---|
| 1949 | U.B.C. - B.A. Honors - English |
| 1954 | U.B.C. - M.D. |
| 1954 - 1955 | Junior Intern - Vancouver General Hospital |
| 1955 - 1956 | Pathology Residency St. Paul's Hospital |
| 1956 - 1957 | Rotating surgical residency, Shaughnessy Hospital |
| 1957 - 1990 | Family practice - Oakridge area - Vancouver. Hospital affiliation - St. Vincent's Hospital. Retired from active practice June 1990. Appointed by Lieutenant Governor in Council as Chairman of Medical Review Panels in January, 1975. |

**Dr. Stanley L. Sunshine**

| | *Professional Education* |
|---|---|
| 1960 | M.D. - U.B.C. |
| 1964 | Fellow, College of Family Physicians of Canada<br>Certificant, College of Family Physicians of Canada |
| | *Professional Activities* |
| 1975 | Appointed Chairman, Medical Review Panels, by Lieutenant Governor In Council |
| 1963 | Active Staff Vancouver General Hospital, Department of Family Practice, V.G.H. and U.B.C. |

| | |
|---|---|
| 1964 | Attending staff Shaughnessy Hospital and Children's' Hospital |
| 1964 - Present | Numerous committee roles at V.G.H., especially in public affairs, public relations and Quality of Care Assurance. |
| | Clinical Instructor, Faculty of Medicine, U.B.C. |

### *Awards and Distinctions*

| | |
|---|---|
| 1992 | Chairman, Medical Advisory Board, Louie Brier Hospital |

## **Dr. Victor Dirnfeld**

### *Professional Education*

| | |
|---|---|
| 1957 - 1961 | University of Manitoba - M.D. |
| 1691 - 1962 | Internship - St. Boniface General Hospital, Winnipeg, Manitoba. |
| 1962 - 1963 | Residency in Internal Medicine at St. Boniface General Hospital, Winnipeg, Manitoba |
| 1963- 1966 | University of Utah. Affiliated Hospitals, Salt Lake City, Utah. |

### *Awards and Distinctions*

| | |
|---|---|
| 1958 | Isbister scholarship for second highest academic standing - University of Manitoba Medical School. |
| 1966 | Diplomate - National Board of Medical Examiners of the United States |
| 1968 | Certification in Internal Medicine - Royal College of Physicians of Canada |
| 1968 | Fellowship Royal College of Physicians of Canada - Internal Medicine. |

### *Professional Activities*

| | |
|---|---|
| 1966 - 1967 | Permanente Clinic, Portland, Oregon - Internal Medicine. |
| 1967 - Present | Private practice as consultant in Internal Medicine, Richmond, B.C. |

Has been a medical consultant to a number of governmental and private organizations. Is active consulting staff at Richmond General Hospital.

Past chairman of the Pharmacy Committee, Medical Records Committee and Education Committee. Permanent member of the Department of Medicine, I.C.U. Committee, Richmond General Hospital.

| | |
|---|---|
| 1979 - 1981 &<br>1984 - 1987 | Chairman of the Department of Medicine, Richmond General Hospital. |
| 1979 - 1981 &<br>1984 - 1987 | Member of the Medical Advisory Committee Richmond General Hospital |
| 1968 - 1980 | On Courtesy Staff at St. Paul's Hospital |
| 1976 - 1990 | Director, Richmond General Hospital Diabetic Day Centre |

Very active in the British Columbia Medical Association, Canadian Medical Association and British Columbia Society of Internal medicine. Has been a member of the Board of Directors of the B.C.M.A., Chairman of the Board of Directors, and currently the honorary Secretary Treasurer. Has been a member of the executive committee and has served on a large number of committees of the B.C.M.A. as a member and chairman. As a member of the Canadian Medical Association he has served as a member of the general council and chairman on a number of committees. He was chairman of the Session of Spring Scientific meeting of the B.C. Society of Internal Medicine. Appointed by the Lieutenant Governor In Council as Chairman, Medical Review Panels in July 1978.

### *Publications & Research*

Has been a member of the Scientific Board of Canadians For Health Research by appointment by B.C. Medical Association.

## Dr. Peter John Banks

### *Professional Education*

| | |
|---|---|
| | Epsom College - School Prefect |
| 1946 | St. Bartholomew's Hospital - M.B., B.S. |
| 1946 | M.R.C.S., L.R.C.P. |
| 1952 | M.R.C.P. (Eng.) |
| 1952 | M.D. (London) |
| 1954 | F.R.C.P. (Canada) (Internal Medicine) |
| 1973 | F.R.C.P. (England) (Internal Medicine) |
| 1974 | D.Sc. (Hon.) University of Hull |
| 1976 | F.R.C.P. (Ireland) (Hon.) |
| 1977 | F.A.C.P. |
| 1946 | House Physician, St. Bartholomew's Hospital |
| 1947 - 1954 | Residencies in Pediatrics, Physiology, Pharmacology, Internal Medicine - University of London, St. Bartholomew's Hospital |

### *Awards & Distinctions*

| | |
|---|---|
| 1992 | B.C. Medical Association Silver Medal of Service |
| 1972 - 1973 | President elect 1972 and President 1973 of the Canadian Medical Association |
| 1980 | Oslerian Orator |
| 1973 - 1974 | President of British Columbia Medical Association |
| 1985 - Present | Chairman of the Board - Shawnigan Lake School |
| 1977 | Awarded the Silver Jubilee Medal of Canada |

*Professional Activities*

Victoria General Hospital
Chief of Medicine
Chief of Staff
Consultant Physician

Royal Jubilee Hospitals, Victoria B.C.
Consultant staff

1964 - 1965 B.C. Medical Association President

Medical Advisor to several areas of the B.C. Government Medical Services & the Medical Services Commission.

Appointed by the Lieutenant-Governor-In-Council as Chairman, Medical Review Panels in April 1986.

*Publications & Research*

Has published over 41 peer-reviewed publications and journals. Has given 43 lectures and addresses both locally and internationally.

### Dr. Darryl G. Morris

*Professional Education*

1951 - 1955 University of B.C. - B.A. (Philosophy & English Literature)

1957 1959 Teacher - Canada-England High School

1960 - 1964 U.B.C. Faculty of Medicine - M.D.

1964 - 1965 Rotating Internship - Royal Jubilee Hospital, Victoria

*Awards and Distinctions*

1964 Surgery proficiency prize - U.B.C. Faculty of Medicine

*Professional Activity*

1965 - 1967 General Practice
Active staff at Vancouver General Hospital

1967 1973 Family practice - Port Alice,

| | |
|---|---|
| | Vancouver Island |
| 1974 - 1986 | Family practice - Burnaby<br>Attending staff, Burnaby General Hospital |
| 1975 - 1984 | Clinical Instructor, Department of Family Practice - U.B.C. |
| 1984 | Medical Director of Medical Services Association |
| 1986 | Appointed Chairman, Medical Review Panels by the Lieutenant Governor In Council |
| | Member of B.C. Medical Association<br>Member of Canadian Medical Association<br>Active in committees in hospitals, universities and College of Family Practice, Canada. |

**Dr. Geoffrey L. Nanson**

### *Professional Education*

| | |
|---|---|
| 1938 - 1946 | B.A. - University of Saskatchewan (Honors - Biology) |
| 1946 - 1950 | M.D. - University of Western Ontario |
| 1950 - 1951 | Internship Vancouver General Hospital |
| 1950 - 1986 | Various refresher courses, C.M.E. sessions, lectures, conventions relating to family practice. |

### *Professional Activities*

| | |
|---|---|
| 1951 - 1986 | Family practice, Vancouver, B.C. |
| 1953 - 1975 | Medical Advisor, Medical Service Association (part-time) |
| 1975 - 1990 | Senior Medical Advisor, Medical Services Plan of B.C. (part-time) |
| 1951 - 1992 | Member of B.C. Medical Association |
| 1958 - 1975 | Member of College of Family Practice |
| 1958 - 1986 | Charter Member Department of Family Practice, Vancouver General Hospital |

| | |
|---|---|
| 1958 - 1986 | Active Staff, Vancouver General Hospital |
| 1986 - Present | Honorary Staff, Vancouver General Hospital |
| | Appointed by Lieutenant-Governor-In-Council as Chairman of Medical Review Panels in April 1986. |

## Dr. J.T. Sandy

### *Professional Education*

| | |
|---|---|
| 1947 - 1951 | M.D. - University of Western Ontario |
| 1951 - 1956 | Internship/Residency - University of British Columbia, Vancouver General Hospital & Shaughnessy Hospital in Surgery. |
| | Specialty Board Qualifications<br>- Certification in General Surgery<br>- Fellow in General Surgery - Royal College of Surgeons of Canada F.R.C.S.C. |
| 1958 | - Diplomate American Board of Surgery |
| 1967 | - Fellow American College of Surgeons |

### *Awards & Distinctions*

| | |
|---|---|
| 1977 | Canadian Silver Jubilee Medal |

### *Professional Activities*

| | |
|---|---|
| | Clinical Professor, Department of Surgery, Faculty of Medicine, University of British Columbia and Vancouver General Hospital |
| 1992 | Founding member at the University of British Columbia Surgical Alumni Association. Membership in 15 societies including the American College of Surgeons, B.C. Surgical Society, B.C. Medical Association, Canadian Association of General Surgeons, Canadian Oncology Society, North Pacific Surgical Association, Osler Society, Vancouver Medical Association, Western Association of Clinical Surgeons. |

| | |
|---|---|
| | Has been an officer in 11 societies and associations. |
| 1960 - Present | Active staff - Surgery, Vancouver General Hospital and Chief of Service of the Surgical Ward.<br>Has been active in the B.C. Health Association as chairman and member of the Medical-Legal Issues Panel. Chairman, Professional Advisory Committee of the B.C. Cancer Agency and a member of the breast tumor group and screening mammography committee of the B.C. Cancer Agency. Appointed Chairman, Medical Review Panels in April 1986. |
| 1955 - 1965 | Medical Officer R.C.A.F. - Reserve Rank Squadron Leader |

*Publications and Research*

Areas of special interest and accomplishment in the discipline of breast screen project and national breast screen programs. Has participated in a number of local and international scientific programs.

Has 14 publications in peer-reviewed journals. Presentation of 16 scientific papers.

## Dr. Robert C. Harrison

*Professional Education*

| | |
|---|---|
| 1943 | M.D. - University of Alberta |
| 1946 - 1951 | Internship/Residency Training - Toronto General Hospital, Toronto Sick Children's Hospital |

Speciality Board Qualifications

| | |
|---|---|
| 1950 | F.R.C.S. |
| 1952 | Diplomate American Board of Surgery |
| 1956 | F.A.C.S. |
| 1951 | Master of Science - Toronto |

## *Awards & Distinctions*

Undergraduate:
Prize in Physiology - Fourth year
Gold medal in Surgery - Final year

Graduate:
Lister Prize (Toronto)
Reeve Prize (Toronto)

| | |
|---|---|
| 1959 | Nuffield Travelling Fellowship to U.K. |
| 1954 | Medals for Surgical Research, Royal College of Physicians and Surgeons of Canada |

## *Professional Activities*

Teaching, professional and research positions held and U.B.C. appointments

| | |
|---|---|
| 1960 - 1966 | Professor of Surgery, University of Alberta |
| 1954 - 1966 | Director of Experimental Surgery, University of Alberta |
| 1951 - 1966 | Instructor to Associate Professor, University of Alberta |
| 1966 | Professor & Head - Department of Surgery, University of B.C. |

Past chairman, Mammography Committee, Cancer Control Agency

Member in following professional and learned societies:

- American Surgical Association
- American College of Surgeons
- Alberta College of Physicians and Surgeons
- Alberta Surgical Society
- B.C. Surgical Society
- Canadian Association of Clinical Surgeons
- Canadian Assoc. of Gastroenterology (President 1983)
- Canadian Association of General Surgeons, founding member

- Canadian Medical Association - past chairman of Cancer Committee and past Executive
- Canadian Society for Clinical Investigation
- Past President of the International Surgical Group
- Medical Research Council of Canada
- First Surgical Member of Council, 1960
- Royal College of Physicians & Surgeons of Canada
- Past member of the General Surgical Committee, Medalist Selection Committee, Departmental Review Committees, and Examinations Committee

Appointed by the Lieutenant Governor In Council as Chairman, Medical Review Panels in April, 1986

*Publications & Research*

27 invited lectureships both nationally and internationally. 160 pre-reviewed publications.

Extensive research over a 25 year period, related to Gastroenterology

## Dr. Peter Allen

*Professional Education*

1947 M.D., B.Sc., Medical School - University of Toronto, Canada

1956 - 1958 McLaughlin Fellowship to study Cardiac and Thoracic Surgery, University of Minnesota

*Awards & Distinctions*

1964 Nuffield Fellowship to study thoracic surgery at Brompton Hospital, London, England

1976 Rose Foundation Award for professional education of physicians abroad (India).

| | |
|---|---|
| 1974 - 1988 | Set up the Peter Allen Essay Award in Society of Thoracic Surgeons of Great Britain & Ireland. |
| 1978 | Gave the annual Osler Address - Vancouver Medical Association |
| 1985 | Order of Merit, B.C. Heart Foundation |

### *Professional Activities*

| | |
|---|---|
| 1980 - Present | Clinical Professor Thoracic and Cardiovascular Surgery, Vancouver General Hospital & University of British Columbia |
| 1978 - 1979 | Head of Department of Cardiothoracic Surgery, University of British Columbia. Director, Undergraduate Education, Medicine |
| 1974 - 1976 | Head of the Department, Cardiothoracic Surgery, University of British Columbia |
| 1965 - 1976 | Clinical Associate Professor<br>Director, Residency Programme, Cardiovascular and Thoracic Surgery, University of British Columbia |
| 1990 - Present | Appointed by Lieutenant Governor in Council in March 1990 as Chairman, Medical Review Panels |
| 1981 - 1987 | Member, Board of Directors, B.C. Heart Foundation |
| 1981 to 1984 | Chairman, Medical Advisory Committee, B.C. Heart Foundation |
| 1978 to 1982 | Western member, Specialty Committee, Royal College of Surgeons of Canada |
| 1968 to 1990 | Member, Clinical Fellowship Selection Committee, B.C. Heart Foundation |
| 1954 - | F.R.C.S. (C) (General Surgery) |
| 1960 - Present | B.C. Surgical Society |
| 1964 | Certified in Thoracic Surgery by RCSC |
| 1964 | Founding member, Society of Thoracic surgeons |

| | |
|---|---|
| 1960 to 1970 | Fellow, American College of Surgeons |
| 1974 - Present | Honorary Member, Society of Thoracic Surgeons of Great Britain and Ireland |
| 1960 - Present | B.C. Medical Association |

*Publications & Research*

| | |
|---|---|
| 1957 - 1988 | Extensive clinical research and basic research in cardiac and vascular systems.<br>34 peer-reviewed publications |

## Dr. Ian David Connell

*Professional Education*

| | |
|---|---|
| 1970 - 1974 | University of Toronto - M.D. |
| 1974 - 1975 | Rotating internship - St. Paul's Hospital, Vancouver, B.C. |
| 1974 | Externship - King's College Hospital, London, England. |

*Awards and Distinctions*

Chairman, Medical Education Committee since 1986 - St. Vincent's Hospital, Vancouver, B.C. Regular lecturer on occupational health in the hospital setting - U.B.C. Department of Medicine and Health Sciences and Section of Occupational Medicine, British Columbia Medical Association.

*Professional Activities*

Has acted as an occupational health physician to eight different organizations within the greater Vancouver area. Currently a physician and surgeon in general practice. On staff at St. Vincent's Hospital and Shaughnessy Hospital, Vancouver, B.C. Has acted as a medical and psychiatric officer for the City of Vancouver, Vancouver Police Department. Appointed by the Lieutenant Governor in Council as Chairman, Medical Review Panels in March 1990.

### Dr. Beverley G. Barron

*Professional Education*

1958 University of Toronto, School of Physical and Occupational Therapy. Physiotherapist's degree.

1961 University of Toronto, Medical School. M.D.

*Professional Activities*

Member, College of Physicians & Surgeons of British Columbia. Member of the Canadian Medical Protective Association. Member Canadian and B.C. Medical Associations.

1972 - 1989 Active staff member of the staff at Lions Gate Hospital. Was a member of the Medical Staff Advisory Council in the capacity of secretary and responsible for rehabilitation services. Now a Member of Staff Emeritus at Lions Gate Hospital (moved to Victoria - 1989). Prior to Medical School, worked as a physiotherapist at the Workers' Compensation Board of B.C. and at Children's' Orthopaedic Hospital, Seattle Washington. High interest in rehabilitation medicine. Currently in association with two general practitioners in Victoria and appointed to the staff of the Greater Victoria Hospital Association. In March 1990 was appointed by Order of the Lieutenant-Governor-in-Council for the province of British Columbia to act in the capacity of Chairman of Medical Review Panels. Has been in general practice since 1962, first in Brampton Ontario and then West Vancouver, except for a period as a Medical Advisor with the Workers' Compensation Board of B.C. from 1968 to 1972.

### Dr. R.S. Purkis

*Professional Education*

1950 B.A. - University of British Columbia

| | |
|---|---|
| 1954 | M.D. - University of British Columbia |
| 1954 - 1955 | Internship at St. Paul's Hospital |
| 1955 | General Surgery, City Hospital, Exeter, England |
| 1956 | Residency in Orthopaedics, Billericay Hospital, Essex (Hammersmith Group, England) |
| 1956 | Nato Forces Europe - Medical Officer Flight Lt. Robert S. Purkis DFC B.A., M.D. France & Germany |
| 1957 | Visiting Staff, St. Paul's Hospital, General Practice |
| 1961 | Appointed to Active Staff, St. Paul's Hospital |
| 1961 - 1970 | Founder and Head, Department of General Practice, St. Paul's Hospital |

### *Awards & Distinctions*

| | |
|---|---|
| 1969 - 1974 | Headed teaching program in family practice. Introduced "Pharmacy Rounds." Founded and chaired initial "Chronic Pain Committee" at St. Paul's Hospital. |
| 1980 | Clinical instructor - U.B.C. Faculty of Medicine |
| 1984 | Appointed Head, Emergency Department, St. Paul's Hospital |
| 1984 - 1989 | Appointed Program Director, Emergency Medicine Residency Training Program U.B.C. and St. Paul's Hospital |
| 1988 | Associate Professor University of British Columbia |
| 1990 | Program Director, Emergency Medicine Residency Training Program U.B.C. and St. Paul's Hospital. Retired July 1991. |

### *Professional Activities*

| | |
|---|---|
| 1976 | Elected Director of B.C. Medical Association |
| 1980 | Elected member of the Osler Society |

| | |
|---|---|
| 1990 | Appointed as Chairman, Medical Review Panel, in March 1990. |

## **Dr. John Sloan**

### *Professional Education*

| | |
|---|---|
| 1965 - 1969 | B.A. (English) University of British Columbia, Vancouver |
| 1969 - 1970 | Bachelor of Science (Cell Biology) U.B.C, Vancouver |
| 1971 - 1972 | MSc (Zoology) U.B.C., Vancouver |
| 1972 - 1976 | M.D. - U.B.C., Vancouver |
| 1976 - 1977 | Rotating internship, Memorial University, Newfoundland, |
| 1983 | Externship in Geriatrics, Shaughnessy Hospital, Vancouver |
| 1984 | Certificant of Canadian College of Family Physicians |

### *Awards and Distinctions*

| | |
|---|---|
| 1992 | Guest on CKNW "House Calls," Medical Radio Program (Art Hister host). |

### *Professional Activities*

| | |
|---|---|
| 1977 | Member, College of Physicians & Surgeons of B.C.<br>Member, B.C. Medical Association |
| 1979 - 1983 | Education Committee, St. Vincent's Hospital |
| 1985 - 1988 | Chairman, Medical Quality Assurance Committee, St. Vincent's Hospital |
| 1988 - 1992 | Chairman, Continuing Medical Education Subcommittee, Geriatrics Faculty Committee, U.B.C. |
| 1989 | Member, Geriatrics Committee, Council on Health Promotion, B.C. Medical Association |
| 1990 | Founding Director, B.C. Association of Geriatric Care Physicians |

| | |
|---|---|
| 1991 - 1992 | First President, B.C. Association of Geriatric Care Physicians |
| 1991 | Member, Health Care of the Elderly Academic Group, Section of Teachers of Family Medicine, College of Family Physicians of Canada |
| 1991 | Post-Graduate Family Medicine Working Group on Health Care of the Elderly, Canadian College of Family Physicians |
| 1985 | Clinical Assistant Professor, Department of Family Practice, U.B.C. |

Since 1978 has been very active in teaching activities relative to the geriatric problems and family practice, U.B.C. During the period from 1987 to 1992 he has been very active in organizing continuing medical education and educational programs on geriatric medicine, in the family practice setting in particular, both locally and nationally and internationally.

### *Publications and Research*

Six recent publications in peer-reviewed journals. Active in the field of research since 1989. Holder of nine research grants in the fields of workshops and nursing home care, anabolic steroids and head fractures, prescribing for the elderly, advising and developing video tapes on cooperation between primary care physicians and nursing staff in long-term care facilities. Appointed chairman, Medical Review Panels in March 1990.

## Dr. John S. Smith

### *Professional Education*

| | |
|---|---|
| 1957 - 1961 | M.A. - Honors animal physiology |
| 1960 | B.M. BCh Oxford |
| 1964 | Member of the Royal College of Physicians of London England |

1969 Fellow of Royal College of Physicians of Canada in internal medicine

## *Awards and Distinctions*

1954 - 1960 State Scholarship The Queen's College Oxford U.K.

## *Professional Activities*

Member of executive of the B.C. Society of Internal Medicine since 1978. Secretary 1980 - 1986. President - 1986 - 1988. Currently Economic Secretary of the B.C. Society of Internal Medicine.

1969 - 1970 Research Fellow in Gastroenterology University of British Columbia

Resident in Internal Medicine Shaughnessy Hospital.

Consultant Internist specializing in diabetes and gastroenterology, Surrey Memorial Hospital since 1969.

1980 - 1982 First Chairman Department of Medicine Surrey Memorial Hospital.

Currently Chairman of Department of Medicine, Surrey Memorial Hospital since 1990.

## *Publications & Research*

Mainly in the area of Gastroenterology and Diabetes.

# APPENDIX 4

## LIST OF SPECIALIST MEMBERS

### ANAESTHETISTS

Colm Cole
Vancouver, B.C.

L.C. Jenkins
Vancouver, B.C.

Lance Mitchell
West Vancouver, B.C.

T.C. Queree
Coquitlam, B.C.

### CARDIOLOGISTS

H. Henning
Vancouver, B.C.

David Hu
Vancouver, B.C.

Victor Huckell
Vancouver, B.C.

Donald Ricci
Vancouver, B.C.

C. Thompson
Vancouver, B.C.

### CARDIOVASCULAR AND THORACIC SURGEONS

P. Allen
Vancouver, B.C.

L. H. Burr
Vancouver, B.C.

A. N. Gerein
Vancouver, B.C.

R. I. Hayden
Vancouver, B.C.

M. T. Janusz
Vancouver, B.C.

A. I. Munro
Vancouver, B.C.

C. L. N. Robinson
Vancouver, B.C.

### DERMATOLOGISTS

B.J. Bendl
Vancouver, B.C.

Wm. McLeod
Vancouver, B.C.

W. D. Stewart
Vancouver, B.C.

### GENERAL PRACTITIONERS
Physical Medicine and Rehabilitation Consultants

L.G. Anderson
Vancouver, B.C.

T.R. Deutscher
Nanaimo, B.C.

S.A. Ezzeddin
New Westminster, B.C.

D.M. Laidlow
Kelowna, B.C.

J.C. Le Nobel
North Vancouver, B.C.

F.T. Murdoch
Kamloops, B.C.

A.C. Pinkerton
Vancouver, B.C.

W. Schamberger
Vancouver, B.C.

Neville J. Smith
New Westminster, B.C.

## GENERAL SURGEONS

G.A. Gell
Pentiction, B.C.

R.M. Christensen
Vancouver, B.C.

R.C. Harrison
Vancouver, B.C.

A.J. Kergin
New Westminster, B.C.

W.J. McLaren
Kamloops, B.C.

H.O.L. Murray
Kamloops, B.C.

C.R. Neve
Marysville, B.C.

J.C. Osborne
North Vancouver, B.C.

P.M. Rebbeck
Vancouver, B.C.
J.T.M. Sandy
Vancouver, B.C.

N. Schmidt
Vancouver, B.C.

L.J. Turner
New Westminster, B.C.

K.S. Weaver
Port Alberni, B.C.

F.G. Westgate
Vancouver, B.C.

S.H. Yoshida
Burnaby, B.C.

## GYNAECOLOGISTS

W.F. Bie
Vancouver, B.C.

John Booth
Vancouver, B.C.

F.E. Bryans
Vancouver, B.C.

C.H. Cronhelm
Vancouver, B.C.

Jonathan Cope
Vancouver, B.C.

Matthew Garrey
Vancouver, B.C.

Stephen Hudson
Vancouver, B.C.

Gary Jackson
White Rock, B.C.

Lorena J. Kanke
Vancouver, B.C.

Shirley A. Reimer
Vancouver, B.C.

Nelson Savein
Burnaby, B.C.

## IMMUNOLOGISTS/ALLERGISTS

D.F. Stark
Vancouver, B.C.

A.D. Tobe
Vancouver, B.C.

H.C.G. Wong
Vancouver, B.C.

## INTERNAL MEDICINE SPECIALISTS

F.H. Anderson
Vancouver, B.C.

Henry Ballon
Vancouver, B.C.

D.V.Bates
Vancouver, B.C.

Carl Birmingham
Vancouver, B.C.

Stephen Blackie
New Westminster, B.C.

E.C. Cameron
Vancouver, B.C.

J. Dick
Ladner, B.C.

James Glassford
Delta, B.C.

J.P. Gofton
Vancouver, B.C.

C.R. Rally
Vancouver, B.C.

Stanford Stordy
Vancouver, B.C.

R.G. Wakefield
Vancouver, B.C.

## NEPHROLOGISTS
(Renal Disease Specialists)

R.W. Lauener
Vancouver, B.C.

J.D.E. Price
Salt Spring Isl., B.C.

## NEUROLOGISTS

Barbara Allan
Vancouver, B.C.

Jeffrey Beckman
Vancouver, B.C.

Christopher Bozek
Burnaby, B.C.

Stephen Clarke
Vancouver, B.C.

Andrew Eisen
Vancouver, B.C.

Howard Feldman
Vancouver, B.C.

R.D. Grosch
New Westminster, B.C.

M.W. Jones
Vancouver, B.C.

M.C. Knazan
New Westminster, B.C.

W.E. Martin
Victoria, B.C.

C.A. Simpson
Victoria, B.C.

Allan Smyth
Victoria, B.C.

V.P. Sweeney
Vancouver, B.C.

B.B. Tessler
New Westminster, B.C.

## NEUROSURGEONS

R.T. Bennett
Victoria, B.C.

W.O. Gittens
New Westminster, B.C.

G.B. Thompson
Vancouver, B.C.

## OPTHALMOLOGISTS

C.W. Beattie
Vancouver, B.C.

H. C. Chew
Vancouver, B.C.

W. Couldwell
New Westminster, B.C.

A. Elliot
Richmond, B.C.

G. Harris
Vancouver, B.C.

J. R. Miller
New Westminster

S.F.J. Pilley
Vancouver, B.C.

P.F. Prasloski
New Westminster, B.C.

J.S.F. Richards
Vancouver, B.C.

Ben R. Wilkinson
Nanaimo, B.C.

## ORTHOPAEDIC SURGEONS

G.S. Aitken
Surrey, B.C.

L.H. Bartlett
North Vancouver, B.C.

H.J. Calder
Victoria, B.C.

K.M.W. Christian
Vernon, B.C.

R.J. Claridge
Vancouver, B.C.
R.E. Currie
Burnaby, B.C.

R.G. Davidson
Vancouver, B.C.

I.G. Dommisse
New Westminster, B.C.

B.E. Driedger
Cranbrook, B.C.

F.A. Ducharme
Prince George, B.C.

J.A. Fenton
Richmond, B.C.

J.A. Fuller
Vancouver, B.C.

F. Hainsworth
Trail, B.C.

D.H. Harder
New Westminster, B.C.

F.C. Harris
Comox, B.C.

R.H. Hawkins
Vancouver, B.C.

T.E. Hicks
Langley, B.C.
K.C. Hill
Burnaby, B.C.

J.E. Hunt
New Westminster, B.C.

A. M. Inglis
Vancouver, B.C.

T.K. Jones
Vancouver, B.C.

N.R. Kastelen
Penticton, B.C.

P.J. Kokan
Vancouver, B.C.

J. Leicester
Kelowna, B.C.

K.S. MacKenzie
Victoria, B.C.

H.C. MacNiel
Vancouver, B.C.

J.P. McConkey
Vancouver, B.C.

G.D. McPherson
Vancouver, B.C.

H.S. Miller
Vancouver, B.C.

John H.W. Oliver
Kelowna, B.C.

M.M. Sabir
Abbotsford, B.C.

R.C. Sweeting
Abbotsford, B.C.

W.J. Thompson
Vancouver, B.C.

P.H. Wright
Burnaby, B.C.

B.T. Yoneda
Victoria, B.C.

## OTOLARYNGOLOGISTS

G.A. Badger
West Vancouver, B.C.

Desmond Bell
North Vancouver, B.C.

Florian Braig
Richmond, B.C.

P.J. Doyle
Vancouver, B.C.

D.A. Gillanders
Vancouver, B.C.

Christopher Mann
Vancouver, B.C.

R.A. McNeill
Vancouver, B.C.

E.G.N. Sinanan
Vancouver, B.C.

Glen Smith
New Westminster, B.C.

I.F. Stewart
New Westminster, B.C.

## PATHOLOGISTS

G.B. Elliott
Vancouver, B.C.

R.A. English
Vancouver, B.C.

G.R. Gray
Vancouver, B.C.

A.H. Pontifex
Surrey, B.C.

## PLASTIC SURGEONS

D.A. Baird
Victoria, B.C.

D.M.P. Guichon
New Westminster, B.C.

D.E. O'Brien
North Vancouver, B.C.

P. Osberg
North Vancouver, B.C.

J.T.B. Quayle
Surrey, B.C.

T.J. Robinson
New Westminster, B.C.

C.F. Snelling
Vancouver, B.C.

R.P. Thompson
Vancouver, B.C.

## PSYCHIATRISTS

T. Berzeredi
Vancouver, B.C.

H.D. McIntosh
New Westminster, B.C.

J.E. Miles
North Vancouver, B.C.

W.J. Pankratz
West Vancouver, B.C.

H.L. Parfitt
Vancouver, B.C.

M. Roburn
Vancouver, B.C.

C. Roy
Vancouver, B.C.

R. Shulman
Vancouver, B.C.

## RADIOLOGISTS

D.J. Dundee
West Vancouver, B.C.

Helen J. Emmons
Vancouver, B.C.

W. J. Nickerbocker
Vancouver, B.C.

J.R. McIver
West Vancouver, B.C.

R.J. Mark
Victoria, B.C.

## RESPIRATOLOGISTS

R.T. Abboud
Vancouver, B.C.

W.W. Arkinstall
Kelowna, B.C.

D.V. Bates
Vancouver, B.C.

T.P. Connolly
Victoria, B.C.

P. Champion
Vancouver, B.C.

G.M. Copland
Vancouver, B.C.

J.A. Fleetham
Vancouver, B.C.

S. Grzybowski
Vancouver, B.C.

M.F. Kilshaw
Victoria, B.C.

S.C.T. Lam
Vancouver, B.C.

J. A. MacCarthy
New Westminster, B.C.

A.J. Nolan
New Westminster, B.C.

D.N. Ostrow
Vancouver, B.C.

J.D Road
Vancouver, B.C.

## RHEUMATOLOGISTS

P.M.G. Cosgrave
Duncan, B.C.

S.F. Fenton
New Westminster, B.C.
A.R. How
Burnaby, B.C.

T. Hunter
Vancouver, B.C.

B.E. Koehler
Vancouver, B.C.

A.C. Patterson
Vancouver, B.C.

G.D. Reid
Vancouver, B.C.

R.S. Rothwell
New Westminster, B.C.

H.B. Stein
Vancouver, B.C.

I.K. Tsang
Vancouver, B.C.

## UROLOGISTS

G.J. Ankenman
Vancouver, B.C.

L. Cox
Victoria, B.C.

L.F. Longpre
West Vancouver, B.C.

G.B. Piercy
Victoria, B.C.

L.D. Sullivan
Vancouver, B.C.

## VASCULAR SURGEONS

A.M.Gerein
Vancouver, B.C.

H. Hildebrand
Vancouver, B.C.

H.K. Literland
Vancouver, B.C.

R. T. Miyagashima
Vancouver, B.C.

A. Salvian
Vancouver, B.C.

J.G. Sladen
Vancouver, B.C.

David Taylor
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# APPENDIX 5

## RELEVANT EXCERPTS FROM THE WORKERS COMPENSATION BOARD ACT.

**Medical review panels**

**58.** (1) The Lieutenant Governor in Council may appoint, on the terms and conditions he establishes, one or more chairmen of medical review panels, and an acting chairman, who may act as chairman whenever a chairman is unable to act.

(2) The Lieutenant Governor in Council shall appoint a medical committee which shall prepare a list of specialists in particular classes of injuries and disabilities in respect of which workers have claimed compensation, which list may be amended from time to time, and may make provision for reimbursement of necessary expenses to members of the committee from the accident fund.

(3) Whenever a worker, not later than 90 clear days after the making of a medical decision by the board, expresses himself in writing to the board as being aggrieved by that medical decision and sends with that writing a certificate from a physician certifying that in the opinion of the physician there is a bona fide medical dispute to be resolved, with sufficient particulars to define the question in issue, the worker shall be examined by a medical review panel appointed in the manner provided in this section.

(4) Whenever the employer or former employer of a worker, not later than 90 clear days after the making of a medical decision by the board, expresses himself in writing to the board as being aggrieved by that medical decision and sends with that writing a certificate from a physician certifying that in his opinion there is or may be a bona fide medical dispute to be resolved, with sufficient particulars to define the question in issue, the worker shall be examined by a medical review panel appointed in the manner provided in this section.

(5) The board may decide that the worker shall be examined by a medical review panel, in which case he shall be so examined in the manner provided in this section.

1968-59-55; 1972-64-27; 1974-101-1,31; 1983-10-21, effective October 26, 1983 (B.C. Reg. 393/83).

**Appointing panels**

**59.** (1) On receipt of the expression in writing made under section 58 (3) or (4), or on a decision being made under section 58 (5), the board shall, within a reasonable period of time, by notice by registered mail, require the worker and his employer each to nominate, from the list mentioned above, within 8 days after receipt of the notice, one specialist in the particular class of injury or ailment in respect of which the worker has claimed compensation, but no specialist may be a member of a medical review panel who

(a) examines workers on behalf of the employer;
(b) has treated the worker;
(c) has acted as a consultant in the treatment of the worker; or
(d) is a partner of, or practises medicine together with such specialist,

and there shall not be on the same panel specialists who are partners or who practise medicine together.

(2) In the event that the worker is

(a) self employed;
(b) the child, parent, brother, sister, husband or wife of the employer; or

(c) a partner in or member of the firm that is the employer,

or the employer has ceased to carry on business in the industry in which the injury or disability occurred, the board shall not require the emplcyer to nominate a specialist under subsection (1), but shall itself nominate a specialist as if it were the employer.

(3) The board shall, within 18 days from the receipt of the nominations, if the specialists are prepared to accept the nominations, appoint the specialists members of a medical review panel to examine the worker and the 2 specialists so appointed together with a chairman shall be a medical review panel.

(4) If a specialist does not accept the nomination or if for any reason he is unable to complete his duties as a member of the panel, another specialist shall be nominated and appointed in his place in the manner provided in this section for the appointment of the specialist; and if the party who expressed the grievance under section 58 (3) or (4) fails to nominate a specialist within 8 days after receipt of the notice, no further proceedings shall be taken under this section with respect to that grievance.

(5) If the party other than the one who expressed the grievance fails or neglects to nominate a specialist within 8 days after receipt of the notice, the minister shall appoint a specialist as a member of the panel, and that member shall be deemed to be appointed on the recommendation of that party.

1968-59-55; 1974-101-1,32.

**Examination**

**60.** Within a reasonable time after the appointment of the specialists, the chairman shall arrange for the examination of the worker, and a review of the records of the board, by himself and the other members of the panel.

1968-59-55; 1974-101-1.

**Decision**

**61.** (1) The decision of a majority of the panel is the decision of the panel, and within a reasonable time after the examination of the worker the chairman shall certify to the board as to

(a) the condition of the worker;

(b) the existence or non-existence of a disability;

(c) if there is a disability, its nature and extent, but not stated in terms of percentage of disability of the whole body;

(d) if there is a disability, its cause and, if there is more than one cause, how much of the disability is related to one cause and how much to another; and

(e) if the worker, though no longer disabled, claims that he had a longer period of disability, total or partial, than that allowed him by the board, then and in that event whether he was in fact disabled as a result of the happening or incident which caused the disability for a longer period than that allowed him by the board, and if so, for what longer period he was disabled and the nature and extent of his disability during the period beyond that allowed him by the board, but not stated in terms of percentage of disability of the whole body.

(2) The panel may, in addition to and separately from the certification required under subsection (1), make a report and recommendations to the board on any matter arising out of the examination and review, and the board shall promptly send a copy of them to the physician whose certificate was sent to the board under section 58 (3) or (4).

(3) The board may submit questions to the panel relating to matters enumerated in subsection (1) and the certificate of the panel shall include answers to those questions.

(4) The panel may receive and accept the evidence that in its discretion it may think fit and proper and essential to the medical problem to be decided.

(5) The panel shall determine its own procedure.

(6) The chairman and other members of the panel have the powers conferred on the board by section 87.

(7) Within 18 days or the further time that the board considers necessary of the receipt of the certificate from the chairman of the medical review panel, the board shall review the claim and send a true and complete copy of the certificate to the worker, to the physician whose certificate accompanied the request under section 58 (3) or (4) and to the employer.

1968-59-55; 1974-101-1,33,33A.

**Costs of examination**

**62.** The costs of examinations under section 58, 59, 60, 61 or 63 are payable out of the accident fund as part of the administrative expenses of the board.

1968-59-55.

**Deceased worker**

**63.** (1) Where the dependant of a deceased worker expresses himself in writing to the board as being aggrieved by the decision of the board concerning the cause of death of the worker, the cause of death of the worker shall be inquired into and ascertained by a medical review panel.

(2) On receipt of the expression in writing, the board shall, within a reasonable period of time, by notice by registered mail, require the dependant and the last employer of the worker each to nominate, from the list mentioned in section 58 (2), within 8 days after receipt of the notice, one specialist in the particular class of injury or ailment alleged by the dependant to have caused the death of the worker, but no specialist who has treated the worker or who has been consultant in respect of the worker for the worker's physician may be nominated or accept nomination.

(3) Where this section is invoked, sections 59 (3), (4) and (5), 60, 61 (4), (5), (6) and (7), 62 and 64 apply with the necessary changes and so far as applicable.

(4) The decision of a majority of the panel is the decision of the panel, and within a reasonable time after the inquiry the chairman shall send a certificate to the board setting forth the cause of death ascertained by the panel.

1968-59-55; 1974-101-1.

**Non-medical facts**

**64.** Where the board or the panel considers that a statement of foundational non-medical facts is necessary to determine the medical dispute, the board shall prepare and deliver the statement to the chairman of the panel for the use of the panel.

1968-59-55.

**Certificates conclusive**

**65.** A certificate of a panel under sections 58 to 64 is conclusive as to the matters certified and is binding on the board. The certificate is not open to question or review in any court, and no proceedings by or before the panel shall be restrained by injunction, prohibition or other process or proceeding in any court or be removable by certiorari or otherwise in any court.

1968-59-55.

**Regulations**

**66.** The Lieutenant Governor in Council may make regulations as to any matter or thing which appears necessary or advisable for the effectual working of sections 58 to 65.

1968-59-55.

# APPENDIX 6

## RELEVANT EXCERPTS FROM BILL 15.

**18.** *Section 58 (3) and (4) of the Workers Compensation Act, R.S.B.C. 1979, c. 437, is repealed and the following substituted:*

(3) A worker is entitled to be examined by a medical review panel if, not later than 90 clear days after the making of a medical finding by the review board or a medical decision by the board, the worker

(a) writes to the board expressing that the worker is aggrieved by the medical finding or decision, and

(b) sends with the writing a certificate from a physician certifying that, in the physician's opinion, there is a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue.

(4) An employer or former employer of a worker is entitled to have the worker examined by a medical review panel if, not later than 90 clear days after the making of a medical finding by the review board or a medical decision by the board, the employer or former employer

(a) writes to the board expressing that the employer or former employer is aggrieved by the medical finding or decision, and

(b) sends with the writing a certificate from a physician certifying that, in the physician's opinion, there is or may be a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue.

**19.** *Section 63 (1) is repealed and the following substituted:*

(1) A dependant of a deceased worker is entitled to have a medical review panel inquire into and determine the cause of death of the worker if the dependant writes to the board expressing that the dependant is aggrieved by a finding of the review board or a decision of the board concerning the cause of death.

**Transitional - outstanding appeals of review board medical findings**

**20.** (1) A worker who, under section 91 of the *Workers Compensation Act*, commenced an appeal of a medical finding of the review board before section 18 of this Act came into force is entitled to withdraw the appeal respecting the medical finding and be examined by a medical review panel under section 58 (3) of the *Workers Compensation Act* regarding that finding if the worker complies with section 58 (3) (a) and (b) of that Act before the appeal is heard.

(2) An employer who, under section 91 of the *Workers Compensation Act*, commenced an appeal of a medical finding of the review board before section 18 of this Act came into force is entitled to withdraw the appeal respecting the medical finding and have the worker examined by a medical review panel under section 58 (4) of the *Workers Compensation Act* regarding that finding if the employer complies with section 58 (4) (a) and (b) of that Act before the appeal is heard.

(3) A dependant of a deceased worker who, under section 91 of the *Workers Compensation Act*, commenced an appeal of a finding of the review board concerning the cause of death of the worker before section 16 of this Act came into force is entitled to withdraw the appeal respecting the finding and have the cause of death inquired into and determined by a medical review panel under section 63 (1) of the *Workers Compensation Act* if the dependent complies with that section before the appeal is heard.

**Commencement**

**21.** (1) Sections 1, 3 and 4 shall be deemed to have come into force on September 28, 1990 and are retroactive to the extent necessary to give them effect on and after that date.

(2) Sections 2, 5 and 6 come into force on January 1, 1992.

(3) Sections 9 and 16 come into force on July 1, 1991.

(4) Section 10 comes into force by regulation of the Lieutenant Governor in Council.

(5) Sections 11 and 12 come into force on August 1, 1991.

# APPENDIX 7

## THE APPEAL PROCESS TO THE MEDICAL REVIEW PANELS
## *REHABILITATION SERVICES & CLAIMS MANUAL WCB B.C.*

Where the reassessment or reconsideration results in no change in the original Compensation Services Division decision, an appeal lies back to the review board or, if the decision involves a medical issue, to a Medical Review Panel.

## #103.00 MEDICAL REVIEW PANELS

Section 58 of the Act provides an appeal procedure which relates to medical decisions only.

### #103.10 Right of Workers and Employers to Appeal

A worker is entitled to be examined by a Medical Review Panel if, not later than 90 clear days after the making of a medical finding by the review board or a medical decision by the Board, the worker

(a) writes to the Board expressing that the worker is aggrieved by the medical finding or decision, and

(b) sends with the writing a certificate from a physician certifying that, in the physician's opinion, there is a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue. (16)

An employer or former employer of a worker is entitled to have the worker examined by a Medical Review Panel if, not later than 90 clear days after the making of a medical finding by the review board or a medical decision by the Board, the employer or former employer

(a) writes to the Board expressing that the employer or former employer is aggrieved by the medical finding or decision, and

(b) sends with the writing a certificate from a physician certifying that, in the physician's opinion, there is or may be a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue. (17)

The right of appeal in fatal cases is considered in #103.70.

The application of these provisions to claims involving commercial fishermen is dealt with in #11.52.

Between July 1988 and June 28, 1991, no appeal to the Medical Review Panel was permitted from a review board finding. Transitional provisions allow workers and employers who had commenced appeals to the Commissioners or Appeal Division under Section 91 prior to June 28, 1991, to withdraw the appeal and initiate a Medical Review Panel appeal. They must, however, comply with sub-paragraphs (a) and (b) above.

### *#103.11 What is a Medical Decision or Finding?*

An appeal under this section lies from a "medical decision" of the Board or a "medical finding" by the review board.

Set out below are the major types of "medical decisions" or "medical findings".

#### A. What is the worker's condition?

The diagnosis of the claimant's condition is a medical decision or finding. For example, decisions that a claimant is suffering from silicosis rather than from some other lung disease, or that a claimant has incurred a torn cartilage in his knee, are medical decisions and may be appealed to a Medical Review Panel.

Whether a claimant's injury amounts to "personal injury" under Section 5(1), or whether his disease should be classified as an "industrial disease" under Section 6(1), are not medical questions. They are non-medical decisions which cannot be appealed to a Medical Review Panel.

#### B. What is the cause of the claimant's condition?

Determining the cause of a condition involves three separate issues.

1. The first issue concerns what is usually termed the "non-medical facts". The non-medical facts are all the events and circumstances which surround and lead up to the worker's claim. They include, for instance, the circumstances of an accident occurring at work, the degree of exposure of the claimant to certain industrial pollutants, and the circumstances of any incident or exposure of the claimant outside of work which may have had some bearing on his condition. Determinations of the non-medical facts are not medical decisions, although medical opinions may be of relevance in ascertaining them.

2. Once the non-medical facts have been determined, a decision may be made as to the medical cause of the claimant's condition. From the medical evidence, the decision maker will learn of the range of possible circumstances that could lead to the claimant's condition. For instance, he will know that silicosis is caused by exposure to silica dust, or that a torn cartilage in the knee may be caused by twisting the knee joint while the foot is fixed to the ground. The non-medical facts will be examined to see if there is anything in them which could reasonably result in the claimant's condition, for example, exposure to silica dust or an accident in which the claimant twisted his knee. A decision will then be made as to the actual cause of the claimant's condition. Where there is more than one possible cause, this may involve selecting the most likely or attributing the condition to two or more causes acting together or in succession. This is a medical decision.

3. Having determined the non-medical facts and made a medical decision as to the cause of the claimant's condition, it remains to be considered whether those decisions bring the condition within the terms of the Act. For example, it must be considered whether the injury arose out of and in the course of the employment under Section 5(1), or the industrial disease was due to the nature of the employment under Section 6(1). This determination is a non-medical decision which is not appealable to a Medical Review Panel. For instance, suppose the non-medical facts are that the claimant fell down the steps of the bunkhouse provided for him by his employer and injured his shoulder. The medical decision is that he has strained a muscle in his shoulder due to the fall. The determination whether a worker is acting within the course of his employment when going down the steps of his bunkhouse is a non-medical decision involving questions of policy and legal interpretation.

### C. Does the worker have a disability and, if so, the extent of the disability?

After a claim for compensation has been accepted, payment of compensation to a worker depends on whether or not he is suffering from a disability.

The word "disability" is not defined in the Act, but it is obviously a concept with medical, economic and legal aspects. Basically, the question is divisible into two subquestions:

1. Does the claimant have any residual effects from the compensable injury or disease?

2. Should those residual effects be classified as "a disability" for compensation purposes?

The first is obviously a medical question appealable to a Medical Review Panel. It requires a determination of how the compensable injury or disease has affected the worker's bodily function, for example, does it affect walking, lifting, eating, working, stamina, etc. A medical decision will also determine whether those effects are permanent or, if temporary, when they have or will have terminated.

The second is a question of law and policy. This can be illustrated by the example of finger amputations. Loss of a full finger is treated as a disability as is the loss of a substantial portion of a finger. But as one gets closer to the tip of the finger, a point must be reached at which the loss of tissue is regarded as too slight to be "a disability". Where that line should be drawn involves a non-medical decision which is based on the medical findings as to the loss of bodily function.

The duration and amount of compensation payable for a disability, while based on medical decisions as to the extent and duration of any limitation of bodily function, also involve economic factors, and require a non-medical decision. This includes the percentage of total disability assessed for the purposes of a disability award and the date for termination of wage-loss payments.

### D. Cause of worker's disability.

Where a worker is suffering from limitations in his bodily function, it is a medical decision to determine from what condition or conditions these limitations arose and, if this has not already been done, the medical cause of those conditions (see heading B). However, it is a non-medical question whether these limitations are a disability which is a compensable consequence of a compensable injury or disease.

Suppose, for example, a claimant with a degenerative disc disease strains a muscle in his back at work and as a result is unable to work because of limitations in the movement of his back. The medical decision is that the limitation of movement is due to degenerative disc disease worsened by the strained muscle in his back. It is a non-medical decision whether this limitation of movement is to be considered a compensable result of the injury at work, a non-compensable result of the degenerative disc disease, or whether compensation is to be apportioned in some way.

### E. Authorization of medical treatment.

A decision authorizing or declining to authorize a particular item of medical treatment is not a "medical decision" for the purposes of an appeal to a Medical Review Panel.

### F. Enhancement of pre-existing condition for the purposes of Section 39(1)(e).

Section 39(1)(e) allows the Board to relieve a class or subclass of employers of the costs of a claim where a portion of the disability has resulted from an enhancement produced by a pre-existing disease, condition or disability. An appeal to a Medical Review Panel is not available against a decision under that section. The appeal is confined to situations which affect the rights of a worker to compensation.

Under its general jurisdiction to determine matters within the scope of the Act, the Board is responsible for determining whether there has been a medical decision. Authority to make this determination is exercised by the Medical Appeals Officers who are responsible for the administration of Medical Review Panel appeals. A decision of a Medical Appeals Officer as to whether there has been a medical decision is appealable to the review board.

## *#103.12 Certificate of Bona Fide Medical Dispute*

An appeal by a worker or employer must be supported by a certificate issued by a physician, certifying that in his opinion there is a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue. In other words, the certificate must state exactly in what respect the physician differs from the medical decision of the Board or medical finding of the review board.

The certificate must be from a "physician". Certificates from "qualified practitioners" or other persons are not acceptable. (18) Furthermore, the certificate must be received from a physician registered under the *Medical Practitioners Act* of this province. On the other hand, it will in some situations be appropriate for the Board to exercise its power under #103.20 when all the requirements of #103.10 have been met except that the certificate is from an out-of-province doctor. These are where:

1. The appellant (either the employer or worker) has tried and failed to obtain a certificate from a physician licensed to practice in the province of British Columbia. There should be evidence of a reasonable attempt.

2. There is some evidence that the certificate which is tendered is that of a physician who is registered to practice in the jurisdiction in which he and the appellant both reside. In other words, the certificate must be submitted by a physician whose standing is, in his own jurisdiction, analogous to that of a physician registered under the *Medical Practitioners Act* of British Columbia.

Where the above two criteria have been met, the Medical Appeals Officer will accept a certificate from an out-of-province doctor and allow the matter to proceed to a Medical Review Panel under #103.20.

The Board determines whether or not there is a bona fide medical dispute. The decision is made by the Medical Appeals Officer with her decision being appealable to the review board. (19)

The Board provides a form of certificate.

The Board will pay for an adequate certificate indicating that there is a bona fide medical dispute which includes the reasons why in the opinion of the physician such a dispute exists.

### *#103.13 Commencement of Appeal*

An appeal to a Medical Review Panel may be brought from an initial decision in the Claims Department, a finding by the review board, or from an Appeal Division decision.

An appeal to a Medical Review Panel by a worker or an employer must be made not later than 90 clear days after the making of a medical finding by the review board or a medical decision by the Board. The Board allows a period of 10 days after the date of the decision or the date of mailing stamped on the letter for delivery of the letter. Therefore, the 90-day period for the appeal to the panel begins on the 11th day. There is no power to extend the time once that 90-day period expires.

Sections 58(3) and 58(4) require that both an adequate doctor's certificate and the worker's or employer's application must be received within the 90-day time limit. However, where one of these documents is received within that period and the other is received within a reasonable period thereafter, the Board considers that there is substantial compliance with the time requirements. While the Board cannot extend the 90-day time limit and authorize the appeal to proceed under #103.10, where there has been substantial compliance, the Board will exercise its power under #103.20 to refer the matter to a Medical Review Panel. This referral is subject to the same conditions regarding expenses as if the appeal were one initiated by the worker or employer and to his meeting the normal requirements for a Medical Review Panel found in #103.10 other than those relating to the time limit. This means in particular that he must satisfy the requirement that a certificate be provided from a physician certifying a bona fide medical dispute.

There are guidelines established as to the meaning of a "reasonable period" as referred to in the preceding paragraph. This requirement applies both to the submission of a second appeal document and to the provision of a further medical certificate or clarification of a medical certificate. A "reasonable period" is considered to be 90 days. This 90-day "reasonable period" will commence with the expiry of the 90-day time limit specified under Sections 58(3) and 58(4) where one of the required appeal documents has not been submitted, or upon the making of a decision that a physician's certificate has not defined or provided sufficient particulars to define a bona fide medical dispute.

Where there has been substantial compliance and the requirements with respect to a "reasonable period" have been met as outlined above, the Medical Appeals Officer will allow the matter to proceed to a Medical Review Panel under #103.20.

## #103.20 Authority of the Board to Refer Claims to a Medical Review Panel

Section 58(5) of the Act provides that "The board may decide that the worker shall be examined by a medical review panel, in which case he shall be so examined in the manner provided in this section."

The expiry of the 90-day time limit on the worker's and employer's right to appeal to a Medical Review Panel is not in itself a valid reason for exercising the power given by Section 58(5). The Legislature has omitted to give the Board any authority to extend that time limit and it cannot be the purpose of Section 58(5) to remedy the absence of such a power. The Board's power under Section 58(5) cannot be used to cure a complete failure to meet the requirements of Section 58(3) or 58(4), although it may be used to refer a matter to a Medical Review Panel where there has been substantial compliance with these requirements as described under #103.13.

The purpose of Section 58(5) is to enable the Board to refer to a Medical Review Panel unusually difficult or complex medical questions which arise for decision as part of the normal decision-making process. In matters which come before it, the Appeal Division has the authority to exercise the Board's discretion to refer a worker to a Medical Review Panel pursuant to Section 58(5) of the Act. The President also has the authority to exercise the Board's discretion to refer a worker to a Medical Review Panel pursuant to Section 58(5) of the Act.

## #103.30 Composition of Medical Review Panels

A Medical Review Panel consists of a Chairman and two specialists.

The Lieutenant Governor in Council appoints one or more Chairmen of Medical Review Panels, and an Acting Chairman, who may act as Chairman whenever a Chairman is unable to act. (20)

Section 58(2) provides that "The Lieutenant Governor in Council shall appoint a medical committee which shall prepare a list of specialists in particular classes of injuries and disabilities in respect of which workers have claimed compensation, which list may be amended from time to time, . . ." (21)

### *#103.31 Nomination and Appointment of Specialists*

After receiving the expression in writing from the worker or employer referred to in #103.10 or after the Board has decided to exercise its power described in #103.20, Section 59(1) provides in part that ". . . the board shall, within a reasonable period of time, by notice by registered mail, require the worker and his employer each to nominate, . . ." from the list mentioned in #103.30, ". . . within 8 days after receipt of the notice, one specialist in the particular class of injury or ailment in respect of which the worker has claimed compensation, . . ."

If the party who expressed the grievance fails to nominate a specialist within eight days after receipt of the notice, no further proceedings are taken with respect to that grievance. (22)

If the party other than the one who expressed the grievance fails or neglects to nominate a specialist within eight days after the receipt of the notice, the Minister must appoint a specialist as a member of the panel, and that member is deemed to be appointed on the recommendation of that party. (23)

In the event that the worker is:

(a) self-employed;

(b) the child, parent, brother, sister, husband or wife of the employer; or

(c) a partner in or member of the firm that is the employer

or the employer has ceased to carry on business in the industry in which the injury or disability occurred, the Board shall not require the employer to nominate a specialist but must itself nominate a specialist as if it were the employer. (24) This nomination will be made by a Medical Appeals Officer on behalf of the Board.

The Board shall, within 18 days from the receipt of the nominations, if the specialists are prepared to accept the nominations, appoint the specialists members of a Medical Review Panel to examine the worker. The two specialists so appointed together with a Chairman are a Medical Review Panel. (25)

### *#103.32 Medical Dispute Concerns Two Specialties*

Both the worker and the employer should receive the same list of specialists for nomination for service on the Medical Review Panel. In cases where more than one specialty is relevant, the worker and employer may each be provided with both lists. This would apply to cases where the medical question in dispute was in a borderline area between two specialties. Where the medical question in dispute involves two disparate specialties (i.e. orthopaedic surgery and psychiatry), a choice must be made as to which of the two specialties is of primary relevance to the matter in dispute. Disparate specialties cannot be combined on one Medical Review Panel.

In certain exceptional circumstances, this will result in a need for two Medical Review Panel appeals on a claim, in different areas of specialization. However, the need for the involvement of specialists from other areas may normally be met by a Medical Review Panel obtaining a consultation report from a specialist in another area.

Where an appeal is being taken to a Medical Review Panel, there can be a question of how to deal with psychological problems without the expense and complexity of a separate psychiatric panel. On this point, it is obviously desirable that a panel of, say, orthopaedic surgeons should not reach conclusions on a complex psychiatric problem that requires the expertise of psychiatrists. On the other hand, there is no objection to a panel of, for example, orthopaedic surgeons reaching a conclusion on the psychological aspect of the matter insofar as the ordinary psychological consequences of injury are a matter normally dealt with by orthopaedic surgeons. In other words, if the main problem is orthopaedic, one would expect a panel of orthopaedic surgeons to comment and advise on any psychological problem to the extent that orthopaedic surgeons normally consider related psychological problems. But if it looks as if the psychological problem is the major disability, it may well be desirable that the panel should be composed from the psychiatric list in the first instance.

### *#103.33 Disqualification of Specialist*

No specialist may be a member of a Medical Review Panel who

(a) examines workers on behalf of the employer;

(b) has treated the worker;

(c) has acted as a consultant in the treatment of the worker; or

(d) is a partner of, or practises medicine together with such specialist, and there shall not be on the same panel specialists who are partners or who practise medicine together. (26)

The exclusion of a specialist who "is a partner of, or practises medicine together with such specialist, . . ." does not apply where the partnership or association no longer exists. In a Board decision, the claimant attended for a medical consultation with Dr. "X", who at the time practised medicine together with Dr. "Y". Two years later, Dr. "X" died. Subsequently, a Medical Review Panel was established. The name of Dr. "Y" was included in the list of specialists available for service on the panel, and Dr. "Y" was the employer's selection. There was no suggestion that the employer knew that the claimant had previously consulted Dr. "X", and there was no objection by the claimant to the appointment of Dr. "Y" on the panel. The claimant's subsequent objection to the validity of the certificate was rejected.

### *#103.34 Failure of Specialist to Accept Nomination or Complete Duties*

If a specialist does not accept the nomination or if for any reason he is unable to complete his duties as a member of the panel, another specialist is nominated and appointed in his place in the manner set out in #103.31 for the appointment of the specialist. (27)

## #103.40 Conduct of Appeal

Within a reasonable time after the appointment of the specialists, the Chairman shall arrange for the examination of the worker, and a review of the records of the Board, by himself and the other members of the panel. (28)

### *#103.41 Statement of Issues*

To avoid the risk of the panel answering questions which are not relevant for compensation purposes, the Board seeks to identify in advance the medical decision that is in dispute, and to identify the relevant questions on which the panel decision is needed.

A statement is prepared by the Board and is sent to the panel which begins with identification of the medical decision that is in dispute, then contains the conclusions relating to non-medical facts, and finally the questions on which the panel decision is needed.

After this document has been drafted, the worker and employer are invited to comment on the document before it is submitted to the panel. The Medical Appeals Officer must determine any dispute regarding this document.

### *#103.42 Non-medical Facts*

An appeal to a Medical Review Panel is from a medical decision of the Board or a medical finding of the review board. The Medical Review Panel must therefore accept the decisions of the Board or findings of the review board on questions of non-medical fact, while the Board or review board must accept the conclusions of the Medical Review Panel on questions of medical expertise. (29)

The non-medical conclusions of fact that have been made are contained in the statement referred to in #103.41. The statement of non-medical facts will contain the relevant facts as found by the Adjudicator, the review board, or the Appeal Division, as the case may be. Any non-medical facts that are necessary for consideration of the medical issue, and that have not been expressly found by one of the adjudicating bodies, will be determined by the Medical Appeals Officer from the evidence and, when there is not sufficient evidence, she will obtain the further evidence required. If it appears to the panel that anything in this statement is significantly wrong, or if the Medical Review Panel requires significant additional non-medical facts for its conclusions, the matter should be referred back to the Board for clarification or addition to the statement of non-medical facts.

Suppose, for example, the statement of non-medical facts says that the worker lived in Ontario for ten years and worked in the coal mines there. The worker himself states to the panel that he has never been to Ontario. If it should appear that there might have been a mistake, the matter should be referred back to the Board for reconsideration of the statement of non-medical facts. But if it should appear that the statement of the worker that he has never been to Ontario has already been considered and rejected as untrue, then the panel must accept that conclusion. It should not attempt to determine the truth of the matter over again. But obviously the panel must go on from there to reach its own conclusions about the medical significance of those facts.

### *#103.43 Questions for Decision by the Panel*

Section 61(1) requires that the Medical Review Panel in each case ". . . shall certify to the board as to

(a) the condition of the worker;
(b) the existence or non-existence of a disability;
(c) if there is a disability, its nature and extent, but not stated in terms of percentage of disability of the whole body;
(d) if there is a disability, its cause and, if there is more than one cause, how much of the disability is related to one cause and how much to another; and
(e) if the worker, though no longer disabled, claims that he had a longer period of disability, total or partial, than that allowed him by the board, then and in that event whether he was in fact disabled as a result of the happening or incident which caused the disability for a longer period than that allowed him by the board, and if so, for what longer period he was disabled and the nature and extent of his disability during the period beyond that allowed him by the board, but not stated in terms of percentage of disability of the whole body."

Each of these questions are put to the panel even though they concern matters not at issue in the decision appealed against.

In addition to the above questions, Section 61(3) provides that "The board may submit questions to the panel relating to matters enumerated in subsection (1) and the certificate of the panel shall include answers to those questions."

The questions which the Board submits to the panel are set out in the statement referred to in #103.41.

### *#103.44 Procedure of the Panel*

The panel shall determine its own procedure. (30) Neither the Board nor the review board have any authority to issue instructions to the panel about the procedure to be followed.

Except in fatal cases, the Act requires that the panel shall proceed by examination of the worker. It is left to the panel to determine what kind of examination is appropriate. But there must in each case be some kind of examination. The requirement that there be an examination of the worker means that an appeal cannot proceed if the worker dies before an examination takes place.

A claimant is obliged to attend the examination when the appeal is initiated by the Board or his employer. If he does not do so, any benefits he is currently receiving will be suspended. If he is not currently receiving benefits, he will be advised that if at any time in the future he attempts to reopen his claim, he will be required to be examined by the Medical Review Panel before the reopening can be considered.

Sometimes a patient may bring someone whom he wishes to have present for the examination. Whether the other person should be present is something for the panel to determine. In any event, the Board has no objection.

### *#103.45 Powers of Investigation*

The Chairman and other members of the panel have the powers conferred on the Board by Section 87. (31)

The panel may receive and accept the evidence that in its discretion it may think fit and proper and essential to the medical problem to be decided. (32)

The panel might find that it needs some additional information before it can reach any conclusions. If it is additional conclusions of non-medical fact that are needed, the matter should be referred back to the Board. (33) Similarly there should be a reference to the Board if what is needed is clarification of the relevant questions that the panel has been asked. (34) If it is medical information, however, then the panel is free to reach its own conclusions about how the information should be obtained. For example, if the panel requires an additional x-ray, or a laboratory test, this can be arranged by the panel, or the panel can ask for it to be arranged by the Board, or it can be done in whatever manner the panel thinks appropriate. The panel can also have the claimant examined by specialists in different areas of medical or other expertise than that of the panel members.

### *#103.46 Expenses*

The reimbursement of the expenses of persons attending Medical Review Panels is dealt with in #100.00.

## #103.50 Certificate of the Panel

Section 61(1) provides in part that "The decision of a majority of the panel is the decision of the panel, and within a reasonable time after the examination of the worker the chairman shall certify to the board as to . . ." the questions shown in #103.43.

Obviously medical science cannot always provide definite answers. While in some cases it may be possible to certify a conclusion in terms of something being so or not so, there are many cases in which a conclusion can only be expressed in terms of probabilities. It is expected that the certificates of the panel will sometimes express conclusions in terms of probabilities rather than certainty.

If a certificate is considered incomplete or ambiguous it is referred back to the Medical Review Panel, as that is the only tribunal with authority under the Act to provide a complete certificate.

### *#103.51 Condition of the Worker*

Under Section 61(1)(a), the Medical Review Panel must certify as to the "condition of the worker".

### *#103.52 The Existence or Non-existence of a Disability*

Section 61(1)(b) requires that the Medical Review Panel certify as to "the existence or non-existence of a disability".

The word "disability" is not defined in the Act, but it is obviously a concept with medical, economic, and legal aspects. Basically, the question is divisible into two subquestions:

1. Does the patient have any after-effects from the compensable injury or disease?
2. Should those after-effects be classified as a "disability" for compensation purposes?

The first is obviously a medical question on which the conclusion of a Medical Review Panel is decisive. The second is a question of law and policy for the Board to determine. Thus, if it appears to a Medical Review Panel that the patient has something, but there is a doubt about whether it should be classified as "a disability", the panel should simply certify what it has concluded the patient has, together with the functional significance of whatever it is. The Board can then determine whether it should be classified as "a disability".

The problem is most likely to arise with regard to internal disorders. But it can be illustrated by the example of finger amputations. Loss of a full finger is treated as a disability. So is the loss of a substantial portion of a finger. But as one gets closer to the tip of the finger, a point must be reached at which the loss of tissue is regarded as too slight to be "a disability". Where that line should be drawn is a question of law and policy for the Board to determine.

The problem can also be considered in relation to pain. The symptoms of pain are entirely subjective. A pain may be described by the patient, and the only question may be one of credibility. If so, a Medical Review Panel cannot certify that the conclusion reached by the Board is either right or wrong. If there is no method known to medical science by which to determine the existence or severity of the pain, the panel could simply certify to that effect. On the other hand, there may be cases where the panel can, as a matter of medical science, contribute something towards an answer to the existence of pain. For example, the panel may be able to certify that the pain described by the patient is consistent with clinical symptoms found by the panel on examination. Or in another case, the panel may be able to certify that it cannot find anything to account for the pain described. If the pain exists, the panel need not concern itself with whether it should be classified as a disability. What the Board needs from the panel is whether the members can tell it anything about the existence or severity of the pain beyond what could be determined by the Board listening to the patient and making its own judgment on his credibility.

Thus the role of a Medical Review Panel in a borderline case is simply to reach a conclusion on what the condition is that the patient has. The panel need not express any opinion on whether that condition should be classified as a disability.

### *#103.53 Nature and Extent of the Disability*

Section 61(1)(c) provides that, if there is a disability, the Medical Review Panel is required to certify as to its nature and extent, but not stated in terms of percentage of disability of the whole body. The latter restriction means that the panel should not certify that a worker has a permanent "total" disability as this suggests an award at 100% of total.

There are two distinct elements in a determination that a person is or is not fit to perform a particular job or occupation. There are, first, the physical requirements of the job and, second, the worker's capability of performing those requirements. The first of these is non-medical in nature and therefore outside the jurisdiction of the Medical Review Panel. The second is a medical matter within the jurisdiction of the panel, but only if there are sufficient facts before the panel which the Board or review board has found regarding the physical requirements of the job. Even then, the panel's certification would not be binding with regard to any job where the Board concluded that the physical requirements were different from those before the panel.

The principles set out in #103.52 also apply here.

Where a pension is assessed or revised following a certificate, the principles followed in determining the date of commencement of the new pension are set out in #41.11.

### *#103.54 Cause of the Disability*

Under Section 61(1)(d), a Medical Review Panel is required to certify as to the cause of the disability. But "cause" refers to the etiology of the condition. It means "cause" insofar as it is a matter of medical science; but not "cause" insofar as it is a matter of moral value judgments, of law, or of non-medical fact.

Suppose, for example, a worker suffers an injury to his hand by catching it in machinery at work. During subsequent medical treatment in hospital, he suffers an infection. The infection results in a disability far greater than would have resulted from the original injury. Suppose then that the question raised is whether the ultimate disability was "caused" by the work injury. That is a broad issue that really incorporates several questions, some medical and some non-medical. The responsibility of the panel in a case of this kind is to consider whether the Board or review board has arrived at correct conclusions on the medical aspects of the matter, i.e. correct conclusions on how and where the infection was contracted, and the medical significance of the infection. But whether the consequences of the infection should be treated as consequences of the original injury for compensation purposes is a question of law and policy that the Board or review board must decide for itself.

Effective March 12, 1990, where a valid Medical Review Panel certificate is received stating that a disability is due in part to a work injury and in part to other non-work causes, the Board should adjudicate the claim exactly as if the medical findings made by the panel had been made by the Board. This means that the Board should decide in each case whether, in light of the medical findings of the panel, the disability results from the injury for the purpose of Section 22, 23, 29 and 30 of the Act and, where appropriate, follow the criteria prescribed by Section 5(5) in determining the amount of compensation payable. The Board should, in doing this, follow the normal policy and practice of the Board for determining eligibility to compensation.

### *#103.55 Duration of Disability*

Section 61(1)(e) provides that the Medical Review Panel must certify, "if the worker, though no longer disabled, claims that he had a longer period of disability, total or partial, than that allowed him by the board, then and in that event whether he was in fact disabled as a result of the happening or incident which caused the disability for a longer period than that allowed him by the board, and if so, for what longer period he was disabled and the nature and extent of his disability during the period beyond that allowed him by the board, but not stated in terms of percentage of disability of the whole body."

### *#103.56 Certificate Binding on the Board*

Section 65 provides that "A certificate of a panel under sections 58 to 64 is conclusive as to the matters certified and is binding on the board. The certificate is not open to question or review in any court, and no proceedings by or before the panel shall be restrained by injunction, prohibition or other process or proceeding in any court or be removable by certiorari or otherwise in any court." This means that any subsequent decision of the Board or finding by the review board, at any point in time, must be consistent with the certificate. For example, a decision by a Medical Review Panel that a worker has no disability can be followed by a Claims Department decision that he has a disability, even a week later if there is **evidence** that he suffered a further disability in this interval. The Claims Department cannot however decide that he has a disability even 10 years later if the medical evidence is such that there has been no change in his condition and it simply alleges that the original diagnosis by the Medical Review Panel was wrong.

To be binding on the Board, however, the document must be "a certificate". This in turn means that the document must relate to issues specified in #103.51-#103.55, and that the decisions made on the appeal must relate to "a medical decision" of the Board or medical finding of the review board. A document is not "a certificate" to the extent that it purports to decide any non-medical issue; for example, a question of non-medical fact, or a question of entitlement to compensation. If the document includes any decisions on those non-medical issues, those decisions are not a legally valid part of the certificate and therefore are irrelevant.

As an example, a compensable injury led to an operation that had not been authorized by the Board. The disability resulted from the operation. The Medical Review Panel stated in its certificate that "the patient's present disability is not due to the accident of June 30, 1971." The conclusion that the disability was not due to the accident was a conclusion of law, not of medical science. It was, therefore, an excess of jurisdiction by the panel, and to the extent that it contained that statement the document was not a certificate under Section 65. It was therefore not binding on the Board, nor was it of any persuasive value. In the certificate, the panel also concluded the disability from which the claimant was then suffering was caused by the operation. That was a conclusion of medical science. To that extent, therefore, the document was a valid certificate and the conclusion binding on the Board.

As far as possible, where a Medical Review Panel disagrees with a Board Medical Advisor/Consultant's opinion, that Medical Advisor/Consultant should not be involved in the immediate implementation of the certificate. This may not be practicable in some situations, for example, if the Board has only one Medical Advisor/Consultant of a particular specialty or he is at a particular location on staff and his advice is required both before and after the certificate.

### *#103.57 Communication of Certificate*

Section 61(7) provides that "Within 18 days or the further time that the board considers necessary of the receipt of the certificate from the chairman of the medical review panel, the board shall review the claim and send a true and complete copy of the certificate to the worker, to the physician whose certificate accompanied the request under section 58(3) or (4) and to the employer."

A copy of the certificate will also be sent to any union representative of the worker.

### *#103.58 Reconsideration of Certificate*

There are two types of new evidence relating to matters to which a Medical Review Panel has certified. The first type is evidence which indicates that the panel made a fundamental mistake concerning the claimant's medical condition or status at the time the certificate was issued. For example, it may become evident that the panel was provided with the wrong x-rays or examined the wrong part of the worker's body. The second type is evidence which indicates that the claimant's condition or status may have changed since the certificate was issued, so that the compensable consequences of the certificate are no longer appropriate. For example, a partial disability may have deteriorated into total disability or a condition not previously disabling may have worsened and become disabling.

As a result of Section 65, the Board, itself, is unable to act on the first type of evidence. That does not necessarily mean, however, that there is nothing which can be done if it is determined that a fundamental mistake was made by a Medical Review Panel. If, within a reasonable period after a certificate is issued, perhaps one year, new evidence becomes available indicating that a fundamental mistake has been made and if it is possible for the Board to reconvene the Medical Review Panel which issued the certificate, the Board may, at its discretion, do so. Where the panel determines that, as a result of its mistake, its previous certificate was wrong, the certificate will be considered null and void and the panel will issue a new certificate to be substituted for it. Where, however, a longer period has elapsed before the mistake becomes evident or the original panel members can no longer be reconvened, the Board will, if it concludes that further action is necessary, convene a new Medical Review Panel. In this case, the certificate of the original panel would be binding up to the date of any certificate issued by the new panel.

The second type of new evidence, that is, evidence indicating that the claimant's condition has somehow changed, may be treated differently. The Medical Review Panel certificate is binding on the Board only as to matters as these stand at and prior to the date of the certificate. As to the extent and nature of disability after the date of the certificate, it is open to the Board to make a decision without reference back to the original panel or to a new panel, as long as that decision is not inconsistent with the Medical Review Panel certificate.

## #103.60 Report of the Panel

Section 61(2) provides that "The panel may, in addition to and separately from the certification required under subsection (1), . . ." (see #103.50) ". . . make a report and recommendations to the board on any matter arising out of the examination and review, and the board shall promptly send a copy of them to the physician whose certificate was sent to the board under section 58(3) or (4)."

An accompanying report is not required in every case, but it is a usual practice. The report normally identifies the material that the panel has seen (apart from its examination of the patient). The report normally states what examination routines the panel itself has carried out, what diagnostic checks the panel has made, and the report also contains anything else that the panel thinks would be of interest to the treating doctor.

The accompanying report is sent by the Board to the treating physician and the members of the panel, but not to anyone else.

It could happen that the panel might reach a conclusion which it feels would be medically harmful to communicate to the patient in the certificate. For example, the panel may feel that the disability will inevitably deteriorate, but that to tell the patient that, particularly if he has not asked the question, may simply make him feel worse without achieving anything. It may not be an answer that is necessary in the certificate. On the other hand, it may be something that the Board and the treating physician should know. Alternatively, there may be something which the patient should be told, but should be told by the attending physician rather than simply receiving it in a document. In a case of this kind, after stating the conclusion in the certificate, the panel may wish to include supplementary information in the accompanying report.

## #103.70 Fatal Claims

Section 63 of the Act provides as follows:

> "(1) A dependant of a deceased worker is entitled to have a medical review panel inquire into and determine the cause of death of the worker if the dependant writes to the board expressing that the dependant is aggrieved by a finding of the review board or a decision of the board concerning the cause of death.
>
> (2) On receipt of the expression in writing, the board shall, within a reasonable period of time, by notice by registered mail, require the dependant and the last employer of the worker each to nominate, from the list mentioned in section 58(2), . . ." (see #103.30) ". . . within 8 days after receipt of the notice, one specialist in the particular class of injury or ailment alleged by the dependant to have caused the death of the

worker, but no specialist who has treated the worker or who has been consultant in respect of the worker for the worker's physician may be nominated or accept nomination.

(3) Where this section is invoked, sections 59(3), (4) and (5), 60, 61(4), (5), (6) and (7), 62 and 64 apply with the necessary changes and so far as applicable. (35)

(4) The decision of a majority of the panel is the decision of the panel, and within a reasonable time after the inquiry the chairman shall send a certificate to the board setting forth the cause of death ascertained by the panel."

In fatal claims, there is no 90-day time limit for a Medical Review Panel and no requirement that the application be supported by a physician's certificate. Nor is an employer able to appeal to a panel in a fatal case. The certificate of the panel as to the cause of death is binding on the Board in the way described in #103.56.

An examination of a worker by a Medical Review Panel and the certificate following such an examination is not binding with respect to a decision on a dependant's claim in respect of the worker's death. Such a certificate is, of course, binding on the worker with regard to any subsequent decisions relating to his condition during his lifetime.

Between July 1988 and June 28, 1991, no appeal to the Medical Review Panel was permitted from a review board finding. Transitional provisions allow a dependant who had commenced an appeal to the Commissioners or Appeal Division under Section 91 prior to June 28, 1991, to withdraw the appeal and initiate a Medical Review Panel appeal.

## #104.00 THE APPEAL DIVISION

The jurisdiction of the Appeal Division is set out in specific sections of the *Workers Compensation Amendment Act*, 1989, as outlined below. In addition, the Governors have designated certain other matters as appealable to the Appeal Division under Section 96(6.1) and delegated the authority of the Board in certain matters to the Chief Appeal Commissioner and the Appeal Division.

### #104.10 Appeals from Review Board Findings

Section 91 provides that where the review board makes a finding under Section 90, the worker, the worker's dependants, the worker's employer or the representative of any of them may, not more than 30 days after the finding is sent out, or within a longer period the Chief Appeal Commissioner may allow, appeal the finding to the Appeal Division.

### #104.20 Referrals of Review Board Findings

Section 96(4) provides that the President may, not more than 30 days after a finding of the review board is sent out, refer the finding to the Appeal Division for redetermination on grounds of error of law or contravention of published policy of the Governors.

## #104.30 Reconsideration of Appeal Division Decisions

Section 96.1 provides that a worker, the worker's dependants, the worker's employer or the representative of any of them may apply to the Chief Appeal Commissioner for reconsideration of a decision of the Appeal Division on the grounds that new evidence has arisen or has been discovered subsequent to the hearing of the matter decided by the Appeal Division.

Where the Chief Appeal Commissioner considers that the evidence is substantial and material to the decision and did not exist at the time of the hearing, or did exist at that time but was not discovered and could not through the exercise of due diligence have been discovered, she may direct that the Appeal Division reconsider the matter or that the applicant may make a new claim to the Board with respect to the matter.

Section 17 of the *Workers Compensation Amendment Act* provides that a worker, the worker's dependants, the worker's employer or the representative of any of them may apply to the Chief Appeal Commissioner for reconsideration of a decision made under Section 91 or 96 of the former *Workers Compensation Act* on the same grounds and in the same manner as that set out in Section 96.1 of the new *Workers Compensation Act*. This means that the Appeal Division also has the jurisdiction to reconsider decisions of the former Commissioners in accordance with the reconsideration provisions of Section 96.1.

The Appeal Division of the Workers' Compensation Board of British Columbia shall exercise the authority of the Workers' Compensation Board of British Columbia under Section 96(2) of the *Workers Compensation Act* to reopen, rehear and redetermine any decision made by the former Commissioners prior to June 3, 1991, where the Chief Appeal Commissioner finds that the decision was based upon an error of law or involved or involves an issue under the *Canadian Charter of Rights and Freedoms*.

## #104.40 Employer Appeals

Section 96(6) provides that an employer who has received notice of an assessment under Section 39, 40, or 41, a classification, special rate, differential or assessment under Section 42, or an additional assessment, levy or contribution under Section 73 may, not more than 30 days after receiving the notice or within a longer period the Chief Appeal Commissioner may allow, appeal the assessment, classification, special rate, differential or additional assessment, levy or contribution to the Appeal Division on the grounds of error of law or fact or contravention of a published policy of the Governors. The published policy of the Governors is set out in #96.10.

In Decision #4 of the Governors, under Section 96(6.1), the Governors have designated that an employer who has received notice relating to an assessment, classification, monetary penalty or apportionment or shifting cost between classes for which no appeal to the Appeal Division is specifically provided in Section 96(6) may appeal to the Appeal Division.

Under these sections, the Appeal Division has jurisdiction to consider appeals from the following decisions:

1. a decision to impose an additional assessment with respect to occupational safety and health matters under Section 73;

2. a decision to impose an additional assessment with respect to first aid matters under Section 70;

3. a decision on any assessment matter;

4. a decision with respect to the application of Section 39(1)(d) or 39(1)(e);

5. a decision with respect to the charging of claims costs under Section 47(2);

There may be other decisions made under the Act which might fall under the provisions of Section 96(6) or 96(6.1). If an employer considers that he has received a decision for which an appeal is provided by Section 96(6) or designated by the Governors under Section 96(6.1) which is not listed above, he should raise the matter with the Appeal Division who will determine whether the Appeal Division has jurisdiction to hear the matter.

### #104.50 Criminal Injuries

Section 12(a) of the *Workers Compensation Amendment Act* amends Section 22(3) of the *Criminal Injury Compensation Act* such that by leave of a criminal injury appeal committee or the Chief Appeal Commissioner, the Appeal Division has jurisdiction over an appeal from a decision of a criminal injury appeal committee.

### #104.60 Delegations to the Appeal Division

In Decision #4 of the Governors, the following authority of the Board is assigned to the Appeal Division by the Governors:

> "The Governors assign to the Chief Appeal Commissioner and the Appeal Division:
>
> 1. The Board's obligation to issue certificates under Section 11;
>
> 2. The Board's authority to reallocate claims costs between employers under Section 10(8);"

## #105.00 PAYMENT OF CLAIMS PENDING APPEALS

### #105.10 Appeals to the Workers' Compensation Review Board – New Claims

The general practice is that no payment is made on a new claim until there has been an adjudication that the claim is valid.

When a decision is made to allow a claim that has been protested by an employer, the employer will be advised of the decision and reasons, where possible by telephone, and given an opportunity to provide any additional information. This is similar to the requirement in #99.10 that a worker be advised if the indication on a claim is that it may be disallowed. If the decision remains that the claim should be allowed, payments will be commenced immediately and a letter explaining the decision and reasons will be sent to the employer. The letter will advise the employer of their rights of appeal.

An employer can appeal up to 90 days from the decision allowing a claim.

If the review board reverses the decision of the Claims Department to allow the claim, payments are immediately terminated but no attempt is made to recover payment incorrectly made to the worker, unless there was evidence of fraud or misrepresentation. The employer will be relieved of the claim costs under Section 39(1)(d).

## #105.20 Appeals to the Workers' Compensation Review Board – Reopening of Old Claims

If a decision is made to reopen an old claim, the employer is advised in writing. If the employer objects to this decision, they will be advised of their rights of appeal.

If the review board reverses the decision of the Claims Department to reopen the claim, payments are immediately terminated. No attempt is made to recover payments incorrectly made to the worker unless there was evidence of fraud or misrepresentation. The employer will be relieved of the claim costs under Section 39(1)(d).

## #105.30 Implementation of Review Board Findings

Section 92 provides as follows:

> "(1) Where a claim is allowed by the review board, periodic payments shall commence, and a lump sum under section 17(13) shall be paid; and an amount so paid is not, in the absence of fraud or misrepresentation, recoverable from the worker or dependants.
>
> (2) Notwithstanding subsection (1), where a finding of the review board is appealed under section 91 or reopened or reheard under section 96, payment of any compensation that has not yet been paid with respect to the period prior to the finding of the review board shall be deferred until the date on which the appeal division makes its decision or redetermination under section 91 or 96, as the case may be.
>
> (3) If the appeal division decision is in favour of the worker or his dependants, interest
> (a) calculated in accordance with the policies of the governors, and
> (b) beginning 31 days after the date on which the review board made its finding or beginning on an earlier day determined in accordance with the policies of the governors
>
> shall be paid on compensation that has been deferred under subsection (2)."

The procedures for implementing all review board findings are as follows:

1. Any benefits payable from the date of the review board finding forward will be paid without delay.

2. Any benefits payable for the period of time prior to the date of the review board finding (retroactive benefits) will be paid after 30 days have elapsed following the date of the review board finding unless:

    (a) the President has referred the review board finding to the Appeal Division under Section 96(4); or

    (b) the employer has commenced an appeal from the finding under Section 91.

3. If there is a referral to the Appeal Division by the President under Section 96(4) or an appeal by the employer under Section 91 retroactive benefits will not be paid until the Appeal Division has completed its consideration of the matter.

4. The decision of the Appeal Division will be implemented upon its receipt by the Board officer. The worker's entitlement to retroactive benefits which were deferred according to #3 above will then be determined in accordance with the decision of the Appeal Division.

5. Where retroactive benefits are payable, after the decision of the Appeal Division, interest is to be paid in accordance with the Board's general policy on the payment of interest on retroactive benefits as set out in #50.00. However, where no interest is payable under #50.00 because the commencement date of the retroactive benefits is less than one year prior to the date the retroactive benefits are being processed, interest will be paid beginning 31 days after the date on which the review board made its finding. The amount of interest to be paid is to be calculated in accordance with the interest rates set out in #50.00.

The implementation of review board findings which result in a lump-sum payment or commutation is discussed at #45.61.

## #105.40 Appeals to a Medical Review Panel

Where the Appeal Division allows a worker's appeal, payment of benefits is commenced even if the employer appeals that decision to a Medical Review Panel or requests the Appeal Division to reconsider their decision.

# NOTES

(1) See #58.00
(2) See #48.46
(3) See #63.10; #63.30; #70.20; #49.00; #45.00
(4) See #25.20, #25.24
(5) See Chapter XI
(6) See #80.00; #81.00; #84A.00
(7) See #88.30
(8) See #35.00
(9) See #40.00
(10) See #45.00
(11) See #114.30-40
(12) See #94.15
(13) S.88(2); See #98.10
(14) See #99.00
(15) S.90(3)
(16) S.58(3)
(17) S.58(4)
(18) See #74.00
(19) See #103.11 Item E
(20) S.58(1)
(21) For the definition of "specialist", see #95.20
(22) S.59(4)
(23) S.59(5)
(24) S.59(2)
(25) S.59(3)
(26) S.59(1)
(27) S.59(4)
(28) S.60
(29) S.64
(30) S.61(5)
(31) S.61(6); See #98.10
(32) S.61(4)
(33) See #103.42
(34) See #103.43
(35) See #103.31-45; #103.57

# APPENDIX 8

## PROPOSED MANUAL AMMENDMENTS.

### #100.00 REIMBURSEMENT OF EXPENSES

Set out below are the rules relating to the reimbursement of expenses for people attonding at the Board or elsewhere in connection with claims decisions.

### #100.10 Claimants

### *#100.11 Medical Examinations*

Expenses will be reimbursed when a claimant is requested by the Board to attend at the Board or elsewhere for a medical examination. In the absence of fraud, these expenses will be paid whether or not a claim is allowed.

### *#100.12 Claims Inquiries, Appeals to the Workers' Compensation Review Board or the Appeal Division*

Where a claimant is attending on a claims inquiry, or on an appeal to the review board or to the Appeal Division, or for a decision review with a Manager, the payment of expenses is discretionary. There will be no undertaking to pay expenses and no advance.

1. Where the claims inquiry, review or appeal results in a decision for the claimant, the discretion will normally be exercised in favour of payment. But payment should be refused if it is concluded that the inquiry or appeal was brought about unnecessarily by the claimant.

   For example, payment might be refused on an appeal where it is concluded that the denial of the claim in the first instance resulted from misleading information supplied by the claimant.

2. Where the claims inquiry, review or appeal results in a decision against the claimant, payment of expenses will normally be refused. But payment may be allowed if there is special reason. An example might be, where, although the claim was unfounded, the bringing of the appeal resulted from misleading reasons for the decision being given in the first instance.

These provisions apply only where people are notified to come for a formal claims inquiry, an appeal or for a decision review with a Manager. Expenses are not reimbursed for people coming to the Board to make enquiries, or for ordinary discussions.

There is one exception to the foregoing. In the case of appeals to the Appeal Division, if an oral hearing is to be held outside the area in which a party resides, the Appeal Division may on request make provision for travel costs in advance of the oral hearing. This would include transportation and accommodation in the Board's Richmond Residence for the appellant and respondent, and would be provided without regard to the outcome of the appeal. Other costs in connection with attending the hearing will be determined in the normal fashion at the discretion of the panel.

### *#100.13 Medical Review Panels*

On an appeal to a Medical Review Panel under Section 58(3) or (4), unless it is concluded that the claimant was misleading his own doctor, expenses will be paid regardless of the result. Travel warrants may be issued, and accommodation in the Rehabilitation Residence (40) may be offered if required. On a reference to a Medical Review Panel under Section 58(5) the reference should include a decision either that expenses will be paid regardless of the result, or that the claimant is being offered the panel on the understanding that the expenses will only be paid in the event of a different decision being reached more favourable to the claimant. Where a claimant resident outside the province appeals to a Medical Review Panel, the Board will pay a flat rate of $300.00 to reimburse him for return air travel between the Alberta border and the lower mainland of British Columbia. This flat rate will normally be a ceiling on such travel costs, however, the circumstances of a particular case may warrant reimbursement of actual travel costs in British Columbia above this amount. Reimbursement on a proportionate basis will apply to any out-of-province claimant who is travelling by air from a location other than Alberta.

This policy applies to travel entitlements which are calculated on or after January 22, 1990 regardless of when the actual travel took place. For claimants who travel from outside the province other than by air, their entitlement will continue to be calculated with reference to their actual travel inside British Columbia, but these costs will normally be subject to the ceiling noted above for air travel costs, and will be in keeping with the general rule in point 3 of #100.14.

Claimants are advised however that, following the receipt of the panel's certificate, the Board may decide to pay expenses for the whole journey. In reaching the decision, the Board considers the contents of the panel certificate.

### *#100.14 Amount of Expenses*

Where expenses are being reimbursed, payment will be as follows:

1. Time spent on the attendance, including travelling time, will be treated as time on compensation, and compensation payments will be made accordingly either as wage loss or as income loss, at the applicable daily wage-loss rate. The payment as wage loss only applies when, under the rules set out in #34.32, wage-loss benefits would ordinarily be payable.

2. In situations where a worker is required to attend for a medical examination at the Board's request or with the Board's approval, or is requested to attend for an inquiry, and where such examination or attendance will require that the worker stay away from home overnight for one or more nights, the Board will reimburse the claimant's actual hotel costs. (In the case of visits to Richmond, claimants will be accommodated in the Richmond Residence.) When contacting the worker prior to his departure from home, the Board officer will reach an agreement with the worker regarding the hotel to be selected and the amount the Board is prepared to approve as a reimbursement. In addition to the hotel costs, the worker will also be paid a full or partial per diem meal allowance of:

| Date | Breakfast | Lunch | Dinner | Per Day |
|---|---|---|---|---|
| September 7 – December 31, 1982 | $6.00 | $7.00 | $13.50 | $26.50 |
| January 1 – June 30, 1983 | 6.28 | 7.32 | 14.12 | 27.72 |
| July 1 – December 31, 1983 | 6.40 | 7.46 | 14.39 | 28.25 |
| January 1, 1984 – September 30, 1989 | 6.59 | 7.68 | 14.81 | 29.08 |

Further additions to this list will be produced as an addendum to this manual.

3. Claimants are expected to use the most economical method of transport reasonably available and, with such limitations, travelling and miscellaneous expenses will be reimbursed on an actual cost basis. Where considered preferable, however, air travel will be allowed.

4. Where a claimant could not reasonably be expected to use public transport, or there is none available, a mileage rate of 27 cents per mile, effective March 1, 1991, will be paid for the use of a private automobile.

5. Where a claimant has used a method of transport more expensive than was reasonably necessary, he will be reimbursed at the rate applicable to the lower cost method.

6. No subsistence is payable when the worker is confined to hospital or can travel from his place of residence to the treatment centre and return daily for return fare less than the subsistence allowance.

7. Where a worker is required to attend for a medical examination at the Board's request or is requested to attend for an inquiry and such attendance will necessitate the purchase of a meal, the claimant will be reimbursed on the basis of the rates per meal set out above.

### *#100.15 Claimant Resides Outside the Province*

Where claimants resident outside the province are requested by the Board to travel from their home, whether it be for a consultation or for a visit to the Board for an interview, usually for the purpose of determining entitlement, the full cost of the trip will be paid by the Board.

Where a claimant resident outside the province has lodged an appeal with either the review board or the Appeal Division, or is attending a claims enquiry at the request of the Board, the entitlement to transportation reimbursement will be considered in accordance with #100.12. Where cases other than Medical Review Panel appeals, as described in #100.12, qualify for payment, such payment will be computed on the basis of a ratio of the distance from Richmond to the British Columbia border in relation to the full distance of the trip. This would not apply however where a decision has been made favourable to a claimant and an employer is appealing that decision and the claimant's attendance at the appeal was felt to be necessary or where the Board has referred the worker to a Medical Review Panel. In such circumstances, the costs of the full trip would be paid. Other details regarding Medical Review Panel travel costs are contained in #100.13.

## #100.20 Employers

The expenses of an employer's representative may be reimbursed on the same basis as for a claimant, except that compensation benefits under #100.14 item 1 are not payable.

Not more than one employer's representative will be eligible for reimbursement for attendance at a claims inquiry or appeal unless the second or other representative is needed as an additional witness.

## #100.30 Witnesses and Interpreters

The expenses of a witness or interpreter will be paid when they have been subpoenaed or have been requested to attend by the Board.

In other cases, the expenses of an independent witness will be paid where, following the inquiry or appeal, it appears that it was reasonable for the claimant or employer as the case may be to have assumed, prior to the inquiry or appeal, that the attendance of the witness would be necessary. (If a claimant or employer intends to bring more than two witnesses, or intends to bring any witness from a distance of more than twenty-five miles, he should check first by telephone with the Adjudicator or the Chairman of the review board, as the case may be.)

Where the expenses of a witness are payable, the amount will be the same as for a claimant except that:

1. No compensation benefits under #100.14 item 1 will be payable.

2. If, to attend the inquiry or appeal, the witness has taken time off from a paid occupation, he will be reimbursed for lost earnings at a fixed rate of the amount set out below per half day, including travelling time.

| Date | Amount Per Half-Day |
|---|---|
| August 2, 1974 – January 31, 1976 | $15.00 |
| February 1 – December 31, 1976 | 18.21 |
| January 1 – December 31, 1977 | 20.89 |
| January 1 – December 31, 1978 | 23.57 |
| January 1 – December 31, 1979 | 25.85 |
| January 1 – December 31, 1980 | 27.32 |
| January 1 – December 31, 1981 | 29.73 |
| January 1 – December 31, 1982 | 33.08 |
| January 1 – December 31, 1983 | 36.96 |
| January 1, 1984 – September 30, 1989 | 40.44 |

Further additions to this list will be produced as an addendum to this manual.

## #100.40 Fees and Expenses of Lawyers and Other Advocates

No expenses are payable to or for any advocate. Nor does the Board pay fees for legal advice or advocacy in connection with a claim for compensation. (41) The Board will not pay the legal costs of a claimant or employer in connection with court proceedings to challenge a Board decision beyond what it may become subject to pay following the court's decision under the general law of costs.

## #100.50 Expenses Incurred in Producing Evidence

Where a claimant incurs expense in producing evidence of a kind which the Adjudicator would have sought himself had it not been produced by the claimant, these expenses will be reimbursed by the Board as an item of administrative cost. In this connection, it makes no difference whether the expense was incurred directly or through a lawyer or other representative. However, confusion should not be made between the expenses incurred by the lawyer or other representative on behalf of the claimant and the fees of the lawyer or representative for his work done. Only the former are reimbursable.

The cost of medical reports obtained by a claimant or employer will also be paid by the Board where, following the inquiry or appeal, it appears reasonable for him or his representative to have assumed, prior to the inquiry or appeal, that the provision of the report was necessary. These costs may be paid even if, after the matter is concluded, it is determined that they had not specifically served to assist in the enquiry.

The Board, in a decision on a claim, refused to pay for medical reports obtained by a claimant's lawyer. Although it was a normal and prudent action on the part of a responsible lawyer to seek information in order to acquaint himself properly with his client's problem before pursuing it before the Board, the information contained in the reports could have been obtained from the claimant's attending physician at no cost. A simple request to the attending physician, together with a release from the claimant, would have been sufficient.

It is not the Board's intention that claimants or employers should incur costs in obtaining evidence, for example, accountants' fees for producing earnings information. Rather, the general approach is that the claimant or employer should advise the Board of possible sources of information and the Board should carry out the necessary inquiries.

## #100.60 Decision on Expenses

With regard to medical examinations and claims inquiries, any necessary decisions relating to expenses would be made by the Adjudicator.

With regard to appeals, the review board or the Appeal Division, as the case may be, will decide on the eligibility for expenses, and where expenses are payable, may either:

1. determine the amount payable, or
2. refer the file back for the amount payable to be determined by the Adjudicator, or
3. determine the amount on some items and refer the file back to the Adjudicator for determination of the amount on other items.

# APPENDIX 9

## INFORMATION FOR PHYSICIANS COMPLETING MEDICAL REVIEW PANEL CERTIFICATES

## INFORMATION FOR PHYSICIANS COMPLETING MEDICAL REVIEW PANEL CERTIFICATES

Section 58(3) of the Workers Compensation Act provides:

> "A worker is entitled to be examined by a medical review panel if, not later than 90 clear days after the making of a medical finding by the review board or a medical decision by the board, the worker
>
> a) writes to the board expressing that the worker is aggrieved by the medical finding or decision, and
>
> b) sends with the writing a certificate from a physician certifying that, in the physician's opinion, there is a bona fide medical dispute to be resolved, and stating sufficient particulars to define the question in issue."

The following information has been prepared to assist physicians who have been asked by a worker, employer, or former employer to complete a Medical Certificate in support of a Medical Review Panel appeal. Please read them carefully before filling out the attached Certificate.

1. You should first identify the medical finding by the Review Board or medical decision by the Board which is in dispute. The worker, employer or dependant should provide you with a copy of the Review Board findings or the Board's decision letter which contains the medical decision being disputed.

2. The Act provides that you must certify that there is a bona fide medical dispute to be resolved. In order for your Certificate to be accepted, you should clearly state that you disagree with the medical finding or decision.

3. The Act provides that you must state sufficient particulars to define the question in issue. In order for your Certificate to be accepted, you should explain how and why you disagree with the medical finding or decision, with medical reasons to support your opinion. Your opinion should be sufficiently detailed to define the medical issue in dispute.

4. Your opinion must be given on a medical basis. In order for your Certificate to be accepted, your opinion must be based upon the facts accepted by the Board. (The facts that have been accepted by the Board will normally be contained in the decision letter under appeal.) Your opinion should not be stated in terms of the compensation benefits to which you think the worker may be entitled.

5. In order for your Certificate to be accepted, the opinion it contains must be your own. You should not certify as to the opinion of the worker or other physicians, etc.

6. Any questions with respect to completion of a Certificate may be directed to Medical Appeals Officer, Appeals Administration Department, Workers' Compensation Board, Box 5350, Vancouver, B.C. V6B 5L5. Telephone: 276 - 3122

Workers' Compensation Board,
Medical Review Panels,
6951 Westminster Highway,
Richmond, B.C. V7C 1C6.

Mailing Address:
Box 5350,
Vancouver, B.C. V6B 5L5.

## CERTIFICATE FOR APPEAL TO A MEDICAL REVIEW PANEL
(Workers Compensation Act)

______________________________ (Worker's Name)

______________________________ (Claim Number)

Where a worker feels aggrieved by a medical finding by the Review Board or a medical decision by the Board, the worker may make a request in writing to appeal the decision to a Medical Review Panel. To permit an appeal there must be a certificate from a physician certifying that, in the opinion of the physician, there is a bona fide medical dispute, and the certificate must state sufficient particulars to define the question in issue.

In accordance with the above requirements, I, Dr. ______________________

of ______________________________ (full address)

have read the decision of the ______________ (decision-maker) dated ______________.

1. I believe that there exists a bona fide medical dispute.
2. I am a physician registered under the Medical Practitioners' Act of British Columbia.
3. The medical decision which I dispute is the decision that:

______________________________

______________________________

______________________________

______________________________

4. The reasons why I believe a medical dispute exists are:

______________________________

______________________________

______________________________

______________________________

5. I have/have not examined the patient.

DATE: ______________________

______________________________ (Personal signature of Physician)

Form 11D4W (R07/91)

# APPENDIX 9.1

## CERTIFICATE FOR APPEAL TO A MEDICAL REVIEW PANEL.

Workers' Compensation Board,
Medical Review Panels,
6951 Westminster Highway,
Richmond, B.C. V7C 1C6.

Mailing Address:
Box 5350,
Vancouver, B.C. V6B 5L5.

## CERTIFICATE FOR APPEAL TO A MEDICAL REVIEW PANEL
(Workers Compensation Act)

______________________________ (Worker's Name)     ____________________ (Claim Number)

Where an employer or former employer feels aggrieved by a medical finding by the Review Board or a medical decision by the Board, the employer may make a request in writing to appeal the decision to a Medical Review Panel. To permit an appeal, there must be a certificate from a physician certifying that, in the opinion of the physician, there is a bona fide medical dispute, and the certificate must state sufficient particulars to define the question in issue.

In accordance with the above requirements, I, Dr. ____________________

of ________________________________________ (full address)

have read the decision of the ________________ (decision-maker) dated ________________.

1. I believe that there exists a bona fide medical dispute.
2. I am a physician registered under the Medical Practitioners' Act of British Columbia.
3. The medical decision which I dispute is the decision that:

________________________________________________
________________________________________________
________________________________________________
________________________________________________

4. The reasons why I believe a medical dispute exists are:

________________________________________________
________________________________________________
________________________________________________
________________________________________________

5. I have/have not examined the patient.

DATE: __________________     ________________________ (Personal signature of Physician)

Form 11D4E (R07/91)

# APPENDIX 9.2

## INSTRUCTIONS FOR WORKERS DESIRING A MEDICAL REVIEW PANEL APPEAL.

## INSTRUCTIONS FOR EMPLOYERS DESIRING A MEDICAL REVIEW PANEL APPEAL.

## INSTRUCTIONS FOR DEPENDANTS DESIRING AN INQUIRY INTO THE CAUSE OF DEATH OF A WORKER.

## INSTRUCTIONS FOR WORKERS DESIRING A MEDICAL REVIEW PANEL APPEAL
## (Workers Compensation Act)

If you wish to have an examination by a Medical Review Panel appointed according to the provisions of the Workers Compensation Act, you may complete the enclosed "Request for Examination" and return it to the Board. At the same time, you should send a certificate from a physician certifying that, in the physician's opinion, there is a bona fide medical dispute to be resolved. The certificate should state sufficient particulars to define the medical question in issue. We enclose a certificate form for completion by your physician.

We would remind you of the provisions of Subsection 58(3) of the Act which requires that your "Request for Examination" and the physician's certificate for appeal must be received by the Board within 90 days of the medical finding or decision which is in dispute.

When the completed "Request for Examination" and physician's certificate are received and if the matter is a proper one for review under the Act, a list of specialists in the particular class of injury or ailment for which you claimed compensation will be provided to you and to your employer. Within eight days of receipt of the list you and your employer will each be required to nominate a specialist as a member of a Medical Review Panel.

Subject to the Board's rules of disclosure, the information contained in the Workers' Compensation Board claim file may be obtained, if you wish, by writing to the Appeals Administration Department, Workers' Compensation Board, Box 5350, Vancouver, B.C. V6B 5L5.

Form 11W77(R07/91)

Workers' Compensation Board,
Medical Review Panels,
6951 Westminster Highway,
Richmond, B.C. V7C 1C6.

**Mailing Address:**
Box 5350,
Vancouver, B.C. V6B 5L5.

## REQUEST FOR EXAMINATION
## BY A MEDICAL REVIEW PANEL
(*Workers Compensation Act*)

Name of worker ______________________ Claim No. ______________

1. I disagree with a medical finding by the Review Board or a medical decision by the Board of ______________ (date) by ______________________ (decision-maker) which refused my request for
______________________________________________
______________________________________________
______________________________________________

2. A certificate is enclosed (will follow/has been sent) from a physician certifying that, in the opinion of such physician, there is a bona fide medical dispute and stating sufficient particulars to define the question in issue.

3. My complaint is in respect of injury to my ______________________ (part of body).

4. This will authorize the Workers' Compensation Board to obtain or view a copy of records pertaining to examination, treatment, history and employment of the undersigned.

______________________
(date)

______________________
(worker's signature)

______________________
(telephone number)

______________________
______________________
______________________
(worker's address)

Form 11W3W (R07/91)

## INSTRUCTIONS FOR EMPLOYERS DESIRING A MEDICAL REVIEW PANEL APPEAL
### (Workers Compensation Act)

If you wish to have a worker examined by a Medical Review Panel appointed according to the provisions of the Workers Compensation Act, you may complete the enclosed "Request for Examination" and return it to the Board. At the same time, you should send a certificate from a physician certifying that, in the physician's opinion, there is or may be a bona fide medical dispute to be resolved. The certificate should state sufficient particulars to define the medical question in issue. We enclose a certificate form for completion by a physician.

We would remind you of the provisions of Subsection 58(4) of the Act which requires that your "Request for Examination" and the physician's certificate for appeal must be received by the Board within 90 days of the medical finding or decision which is in dispute.

When the completed "Request for Examination" and physician's certificate are received, and if the matter is a proper one for review under the Act, a list of specialists in the particular class of injury or ailment for which the worker claimed compensation will be provided to you and to the worker. Within eight days of receipt of the list, you and the worker will each be required to nominate a specialist as a member of a Medical Review Panel.

Subject to the Board's rules of disclosure, the information contained in the Workers' Compensation Board claim file may be obtained, if you wish, by writing to the Appeals Administration Department, Workers' Compensation Board, Box 5350, Vancouver, B.C. V6B 5L5.

Form 11W77E (R07/91)

Workers' Compensation Board,
Medical Review Panels,
6951 Westminster Highway,
Richmond, B.C. V7C 1C6.

Mailing Address:
Box 5350,
Vancouver, B.C. V6B 5L5.

## REQUEST FOR EXAMINATION BY A MEDICAL REVIEW PANEL

(Workers Compensation Act)

Name of worker ______________________ Claim No. ______________

1. We disagree with the medical finding by the Review Board or the medical decision by the Board of ______________ (date) by ______________________________ (decision-maker).

2. A certificate is enclosed (will follow/has been sent) from a physician certifying that, in the opinion of such physician, there is a bona fide medical dispute and stating sufficient particulars to define the question in issue.

______________________
(date)

______________________
(employer's signature or that of an authorized signatory)

______________________
(telephone number)

______________________
______________________
______________________
(employer's name and address)

Form 11W3E (R07/91)

# INSTRUCTIONS FOR DEPENDANTS DESIRING AN INQUIRY INTO THE CAUSE OF DEATH OF A WORKER
## (Workers Compensation Act)

If you wish to have an inquiry made by a Medical Review Panel appointed according to the provisions of the Workers Compensation Act, you may complete the enclosed "Request for an Inquiry" and return it to the Board.

Unlike workers and employers, a dependant does not require a physician's certificate to pursue a Medical Review Panel appeal. A completed "Request for an Inquiry" form or a letter is enough. Another difference is that there is no 90-day time limit following a medical finding or decision in which a Medical Review Panel appeal must be initiated.

When your completed "Request for an Inquiry" or letter is received, and if the matter is a proper one for review under the Act, a list of specialists in the particular class of injury or ailment which is claimed to have caused the death of the worker will be provided to you and to the worker's last employer. Within eight days of receipt of the list, you and the worker's last employer will each be required to nominate a specialist as a member of a Medical Review Panel.

Subject to the Board's rules of disclosure, the information contained in the Workers' Compensation Board claim file may be obtained, if you wish, by writing to the Appeals Administration Department, Workers' Compensation Board, Box 5350, Vancouver, B.C. V6B 5L5.

Form 11W77D (R07/91)

Workers' Compensation Board,
Medical Review Panels,
6951 Westminster Highway,
Richmond, B.C. V7C 1C6.

**Mailing Address:**
Box 5350,
Vancouver, B.C. V6B 5L5.

# REQUEST FOR AN INQUIRY BY A MEDICAL REVIEW PANEL INTO THE CAUSE OF DEATH OF A WORKER

## (Workers Compensation Act)

Name of worker ______________________________ Claim No. ______________

1. I am the (______________________) of the above-named deceased worker.
(dependent relationship)

2. I am aggrieved by the medical finding by the Review Board or the medical decision by the Board of ____________________ (date) by __________________________ (decision-maker) concerning the cause of death of the worker and denying my application for dependant's benefits.

______________________________
(date)

______________________________
(dependant's signature)

______________________________
(telephone number)

______________________________
______________________________
______________________________
(dependant's address)

Form 11W3D(R07/91)

# APPENDIX 10.1

## AN OVERVIEW FOR THE ASSISTANCE OF NEW MEDICAL REVIEW PANEL CHAIRMEN.

### 1. STRUCTURE OF W.C.B.

| | |
|---|---|
| Acting Chairman: | F.W. (Bill) Greer |
| Commissioners: | Beverley Korman<br>Joan N. Nutter<br>Erik Wood |
| Appeals Administration Department: | |
| Director: | Nick C. Attewell |
| Manager: | Diane J. Green |
| Appeals Administrators: | Herb Morton<br>Randy Lane<br>Allan Tuokko<br>Janice Page |
| Senior Medical Appeals Officer: | Judy Olson |
| Medical Appeals Officers: | Kris Newman<br>Dianna Brett<br>Bev Harwood |
| Appeals Officers: | Steve Fielding<br>Marie Roy<br>Morag Brown<br>Nora Cameron<br>Gwenda Hughes |
| Appeals Clerks: | Lisa Dickson<br>Margaret Shea<br>Anne Toews |
| Panel Scheduling: | Francine McCullough |

### 2. OUTLINE OF WORKERS COMPENSATION SYSTEM

#### (a) Objects of Workers Compensation Act

The Workers Compensation Act has two main objects:

1. The prevention of occupational injuries and disease, and

2. The payment of compensation for occupational injuries and diseases which have occurred.

The Medical Review Panel is concerned solely with the second of these objectives.

## (b) Eligibility for Compensation

In order to have a valid claim for compensation, the following requirements must be met:

1. An application for compensation must be made by a worker or dependent of a deceased worker.

2. The worker must have been employed in an industry covered by Part 1 of the Act. Some industries are excluded from coverage, for example, banks and insurance.

3. The worker must suffer personal injury or death arising out of and in the course of his employment or disablement or death caused by an "industrial disease" due to the nature of his employment. Only diseases designated as such by the Board are "industrial diseases".

The existence of a pre-existing condition is not a bar to a claim but the Board may apportion its responsibility in certain circumstances, notably when the previous condition was disabling.

## (c) Type of Compensation

The types of compensation payable are:

1. Wage loss benefits for "temporary total" or "temporary partial disability": These payments cover the acute phase of recovery following the injury or disease, and terminate when the worker recovers or his condition becomes permanent or stabilizes. They may also be paid if, following an initial recovery or stabilization, the claimant suffers a recurrence of temporary disability due to the compensable injury or disease. The amount of full wage loss benefits is 75% of the worker's pre-injury earnings, up to the statutory maximum (now $43,400).

2. Permanent partial or total disability awards: These are payable after the temporary disability stabilizes and wage loss benefits are terminated. There are two types of award:

   i) Physical impairment awards based on the loss of body function of the worker. A percentage of disability is assessed which is applied to 75% of the worker's pre-injury earnings up to the maximum. The award may be granted as a monthly pension or lump sum.

   ii) Loss of earnings awards where the worker cannot return to his previous work. An assessment is made of employment which is suitable for the worker's impairment and likely over the long term to be available to the worker. If the difference between the earnings in this employment and the pre-injury earnings (up to the maximum) exceeds the physical impairment award, an additional award is granted equal to 75% of the difference.

A permanent disability may be reassessed if there is a change in the permanent disability following the initial pension assessment.

3. Medical aid: The Board pays for all medical treatment resulting from the injury.

4. Vocational Rehabilitation: The Board has a discretion to provide retraining or other assistance needed to enable a disabled worker to find alternative employment.

5. Where a dependent of a deceased worker is claiming, benefits vary according to the age, number and type of dependent. A lump sum or monthly pension may be payable.

Unlike the courts, the Board does not pay compensation for pain and suffering or loss of enjoyment of life.

### (d) Adjudication/Appeals Procedures

1. All initial decisions on claims are made by a Claims Adjudicator in the Claims Department.

2. The decision of the Claims Adjudicator is subject to a management review within the Claims Department, upon request.

3. From the decision of the Claims Adjudicator or Manager, there is a choice of appeal. The normal route is an appeal to the Workers Compensation Review Board within 90 days. This appeal may be taken on any issue affecting a worker. The alternative is an appeal to the Medical Review Panel within 90 days where the issue is a medical one.

4. After a Review Board finding, there is an appeal to the Commissioners within 60 days on any issue. There is no appeal from a Review Board finding to the Medical Review Panel.

5. After a Commissioners' decision, the only avenue of appeal is to the Medical Review Panel within 90 days on a medical issue. The Commissioners have authority to reconsider their prior decisions.

Recent legislation has been passed which, when proclaimed in effect, will leave the present appeal system essentially unchanged save that the Commissioners will be titled Appeal Commissioners.

### (e) MEDICAL REVIEW PANELS

An appeal to an MRP may be brought by either a worker or employer, or the Commissioners of the Board may refer the worker for an MRP examination. The worker or employer may appeal to an MRP after a medical decision by an officer of the Board (e.g. Claims Adjudicator), or after a decision by the Commissioners.

A dependent of a deceased worker may also request an MRP inquiry into the cause of death of the worker.

An appeal lies only against a "medical decision of the Board". To initiate an appeal, the appellant must provide a certificate from a physician certifying that in the opinion of the physician there is a bona fide medical dispute to be resolved, with sufficient particulars to define the question in issue.

The determination as to whether the requirements for appealing to a Medical Review Panel have been met is made by the Medical Appeals Officers in the Appeals Administration Department of the Board. Provided the requirements of Section 58(3) or (4) of the Workers Compensation Act are met, such an appeal is a right granted by statute. An application cannot be rejected merely because the dispute involves a minor or trivial issue, so long as there is a bona fide medical dispute. The Medical Appeals Officer prepares a Statement of the Non-Medical Facts found by the Board which is binding on the Panel. She also prepares a list of questions for the Panel. There is a right of appeal to the Review Board and Commissioners from her decision.

Appeals Officers have the function of obtaining all relevant medical information which is not in the Board's possession and may be useful to the Panel. This includes the originals of x-rays.

Each panel comprises two specialists and a Chairman. The Chairman is selected by the Board from a list of doctors appointed by Order in Council and the claimant and employer each nominate a specialist in the area of injury from a list prepared by a joint committee of the B.C.M.A. and the College of Physicians and Surgeons. The list is sent to the parties by the Appeals Officer.

Appeals Clerks in the Department arrange the date for the Panel examination with the claimant and the three Panel members (see Appendix A).

The Certificate of the Medical Review Panel is binding on the Board if it deals with medical matters within its jurisdiction. All Certificates received by the Board are reviewed by Appeals Administrators in the Appeal Administration Department to determine whether the Panel has answered the questions posed, is clear and has not dealt with matters outside the Panel's jurisdiction. They may request clarification from the Panel.

The Commissioners have an overall residual jurisdiction to review a decision of a Medical Review Panel (MRP) to ensure that its Certificate is valid (i.e. the findings of the Panel are responsive to the questions posed, and are within their jurisdiction).

The Board may occasionally ask a Panel to reconsider a previous Panel decision on the basis of new evidence, but this is extremely rare.

Normally, it is only done when there appears to be a clear error in the previous conclusion of the Panel.

## 3. CONFLICTS OF INTEREST

Section 59 sets out the manner in which the members of a Panel are appointed. It should be noted that no specialist may be a member of an MRP who:

a) examines workers on behalf of the employer;
b) has treated the worker;
c) has acted as a consultant in the treatment of the worker;
d) is a partner of, or practices medicine together with such specialist,
and there shall not be on the same Panel specialists who are partners or who practice medicine together.

It is expected that a Panel Chairman will also avoid potential conflict of interest situations. Section 59 identifies five specific categories of conflict of interest situations, but this list may not be considered exhaustive. A Chairman or member should also consider declining service on a particular Panel if there are facts which could give rise to a reasonable apprehension of bias. This could include kinship, personal friendship, or a business relationship with one of the parties to the proceeding. Whether or not this is legally required, it is an appropriate precaution in ensuring that "justice is seen to be done".

## 4. ISSUES

On all MRP appeals brought by a worker or employer, there will be a specific medical dispute which the Panel is needed to resolve. The worker or employer will have submitted a Certificate from a physician, certifying as to the existence of a bona fide medical dispute, with sufficient particulars to define the question(s) in issue. The purpose of the Panel is to resolve this specific dispute.

The Panel is not restricted, however, to resolving the dispute defined by the physician's Certificate. Rather, this Certificate is the key which unlocks the door to the MRP inquiry. The Panel is required to certify to the Board on a list of different issues, and the Panel must reach its own conclusions on all medical issues before it. The list of Issues is drafte by a Medical Appeals Officer, and is attached to the Statement of Foundational Non-Medical Facts provided to the MRP. The Panel's Certificate should respond to all the Issues posed, even if it is simply t state that the particular issue is not applicable, or has been dealt with elsewhere in the Certificate.

It is not open to the Panel to indicate that it is unable to come to a decision. This would amount to the Panel declining to exercise its jurisdiction. If the inability to reach a conclusion is due to a lack of medical or factual evidence, the Panel may wish to consider whether it should pursue such evidence, possibly with the Board's assistance.

## 5. JURISDICTION

An MRP has ultimate jurisdiction to determine a medical question but has no jurisdiction to determine a factual or legal question, or questions as to compensation entitlement. This should be kept clearly in mind in conducting an examination or issuing a Certificate.

The Panel's Certificate must be stated in medical terms without reference to the compensation consequences this might have for the worker or employer. For example, if the Panel considers the worker to have been disabled for a longer period of time than the Board has recognized, the Panel should simply state this in medical terms as to the relevant time frame and extent of disability. It is inappropriate for a Panel to comment with respect to matters of compensation entitlement such as wage loss benefits or pension benefits. For example, the Panel may find that the worker was temporarily totally disabled (and the Board would then conclude that wage loss benefits were payable), or the Panel might find that the worker's disability was stable or "plateaued", or that any further deterioration would take place gradually over the long term (and the Board would consider the worker's entitlement to a pension). Of course, the Panel members may well be aware of the probable significance of their medical findings on the questions of compensation entitlement, but this is essentially irrelevant to the Panel's medical decision-making.

To the extent the Panel states its findings in non-medical terms, its Certificate may be rendered invalid. As the Panel only has jurisdiction t consider the medical issues, it must accept as binding the Board's decision on non-medical facts.

The jurisdiction of a Medical Review Panel is also discussed under #6 Non-Medical Facts, #12 Treatment, #13(b) Percentage of Disability, #13(c) Employability/Fitness for Particular Jobs, and #13(d) Permanent Total Disability.

## 6. NON-MEDICAL FACTS

A Medical Appeals Officer will prepare a Statement of Foundational Non-Medical Facts, as found by the Board. These findings may be appealed by the worker or employer to the Review Board or to the

Commissioners if there are any factual disputes, as those are the appeal bodies which have jurisdiction to resolve factual disputes. The Panel mus accept as correct the findings of fact in the Statement. If it appears to the Panel that anything in the Statement is significantly wrong or if additional factual information is required for the Panel to reach a decision, the matter should be referred back to the Board for clarificatio or addition to the Statement of Facts. If the factual dispute has already been considered by the Board and a decision has been rendered on the factual issue, that decision must be accepted by the Panel. Obviously, however, the Panel must go on to reach its own conclusions about the medical significance of the factual findings.

## 7. PROCEDURE

### (a) Determined by Panel

An MRP has the authority to determine its own procedure. The Panel may receive and accept the evidence that in its discretion it may think fit and proper and essential to the medical problem to be decided.

### (b) Medical Records

The Board will provide the MRP with all of the claimant's medical records from relevant claim files. The Board will also try to obtain original CT scans and x-rays for review by the Panel. The Board does not usually provide the claimant's non-medical records from the claim file, although these will be provided if requested by the Panel.

### (c) Subpoena

An MRP has the legal authority to issue a subpoena to compel the attendance of a witness or the production of records (including a treating physician or his records). The Panel may also request the assistance of the Board in obtaining additional records or information.

### (d) Examination

Except in fatal cases, the Act requires that the Panel shall proceed by examination of the worker. It is left to the Panel to determine what kind of examination is appropriate, but there must in every case be an examination. If the worker has fully recovered, it may be that the Panel will have to base its decision primarily on the available medical records, but some examination is still legally necessary.

### (e) Representatives

Sometimes a worker may bring someone whom he wishes to have present at the examination. Whether the other person should be present is something for the Panel to determine. In any event, the Board has no objections.

If the worker brings a representative, and if the Panel concludes that the worker should be examined in the absence of the representative, it is a most desirable practice for the Panel to indicate that it will listen to anything that the representative may wish to say either before or after the examination.

### (f) Interpreters

If the Board considers it necessary, it will arrange for an interpreter to be present at the Panel examination. The decisions as to whether or not the interpreter is admitted to the examination or how the interpretation services are utilized remain the Panel's. Similarly, the worker may bring a friend or family member as an interpreter. In either case, the extent of the interpreter's involvement is for the Panel to determine.

### (g) Additional Medical Testing

If the Panel requires additional medical information, the Panel is fre to reach its own conclusions about how the information should be obtained. For example, if the Panel requires an additional x-ray or laboratory test, this can be arranged by the Panel or the Board or in whatever manner the Panel thinks appropriate. The Panel may also obtain a consultation report from a specialist in another specialty, if necessary. A special consultation fee would be payable, which would depend on the nature of the report requested. The Panel may request such a consultation either before or after its own examination, prior to issuing a Certificate. For example, a Panel may request a report from a psychologist, or an epidemiologist, or a person engaged in specialized research or testing, and so on, as the Panel considers necessary to its decision.

### (h) Location

MRP examinations are customarily held in the office of the Panel Chairman. The Panel might wish to schedule the examination in the office of one of the specialists, however, if the examination would involve the use of special equipment. This is a matter for the Panel to determine. A Panel might even be asked to examine a worker in hospital if he was not fit to travel.

## 8. PANEL CONCLUSIONS

### (a) Certificate

The Panel is required to produce a Certificate in which the Panel certifies to the Board its conclusions on the issues posed. The conclusions of an MRP contained in a valid Certificate are legally binding on the Board. This Certificate is normally signed by all thre Panel members, although the Chairman's signature alone is legally sufficient. If there are any differences of opinion, the Chairman certifies as to the majority decision of the Panel, which may not necessarily be his own opinion. Copies of the Certificate are forwarded by the Board to the worker, the employer, and their representatives, as well as to the physician whose certificate initiated the appeal.

The Medical Review Panel's Certificate may be addressed to N.C. Attewell, Director, Appeals Administration, WCB.

### (b) Report

There is no legal requirement that an accompanying narrative report b prepared, but it is a usual practice. It is preferred that the narrative report be sent to the Board at the same time as the Certificate, and that it be signed by all three Panel members. A cop of the narrative report will be sent by the Board to the physician whose certificate initiated the appeal. The worker, employer or thei representatives are not provided with copies of the narrative report, although it will be disclosed by the Board together with the other records on file if requested in connection with an appeal. Such a report may serve the following purposes:

i. Reasons for Conclusions - The Panel may wish to explain the reasoning behind its conclusions to assist the reader in understanding the decision.

ii. Clarification of Certificate - The Panel may wish to elaborate in greater detail concerning the conclusions contained in the Certificate. This could be of assistance to the Board in implementing the Panel's decision.

iii. Details of Panel's Examination - It is useful for the Panel to record in its report details of the history or statement given by the worker to the Panel, as well as the Panel's findings concerning the physical examination of the worker. This may include an account of the worker's present complaints, past illnesses, family history, and personal history. The Panel must ensure, however, that the Statement of Foundational Non-Medical Facts, and not the facts as stated by the claimant at the time of the examination, is used as the factual basis for the Panel's medical findings.

iv. Confidentiality - As part of its medical examination, the Panel may incidentally diagnose medical conditions unrelated to the issues before the Panel. The report provides a mechanism to convey their findings in confidence to the claimant's attending physician. There may be matters which the Panel feels would be medically harmful to communicate to the worker in a Certificate which will be sent to all interested parties. There may be something which the patient should be told, but which should be told to him by the attending physician rather than by simply receiving it in a letter.

The narrative reports are reviewed by Appeals Administrators and should the Panel make any comments in the report such as those outlined above, the Administrator will alert the worker and the doctor in a letter by advising that they may wish to discuss the contents of the report with each other. This ensures that while any important matters are brought to the attention of the worker and his or her doctor, the worker receives the information in a confidential doctor-patient discussion.

v. Record of Information Considered - The Panel may wish to summarize briefly the medical information considered. The Board may in the future receive a request that the Panel be reconvened on the basis of significant new medical evidence or on the basis that there was significant medical evidence which was not provided to the Panel. For this purpose, it may be helpful to have a record of the information considered by the Panel. It is not necessary, however, to repeat the contents of the medical records, as these will always be available for reference in the Board's files.

## 9. CLARIFICATION OF CERTIFICATE

The Board may require clarification from the Panel of its Certificate, if there is a perceived ambiguity or other defect in the Panel's Certificate. The Board's usual practice in such cases is for an Appeals Administrator to request clarification from the Panel. As the Panel's Certificate is a legally binding document, only a Panel has authority to amend it. It is therefore requested that all three Panel members sign any letter of clarification. Once the Panel has issued its Certificate, it has discharged its duties and loses jurisdiction to consider the matter further, unless it is requested by the Board to clarify its Certificate or reconsider its decision.

As there is always the possibility that a Panel may be asked to reconvene in the future after issuing a Certificate, Panel members should refrain from discussing the case with the worker, employer, Board employees, or any other interested party. This will assist in avoiding any future allegation of bias which might disqualify the Panel from considering the matter further.

## 10. CERTIFICATE OF A MEDICAL REVIEW PANEL

### (a) Degree of Certainty

It is recognized that medical science cannot always provide definite answers. While in some cases it may be possible to certify a conclusion in terms of something being so or not so, there are many cases in which a conclusion can only be expressed in terms of probabilities. It is expected that the Certificate of a Panel will sometimes express conclusions in terms of probabilities rather than certainty. Panels often use words such as "possible" and "may". Any words or combinations of words implying that the chances are 49% or less that there is a causal relationship may be interpreted by the Board to mean that there is insufficient evidence of a link. Board responsibility only results where, at a minimum, the possibilities that there is a causal link are evenly balanced (i.e. 50% or better). It i for this reason that there is a note at the bottom of all sets of Issues referring to alternative possibilities. The Board has no objection to the use of qualifying phrases, given that it is recognize that medicine is not an exact science. However, the significance of these qualifying words should not be forgotten when Certificates are drafted.

### (b) Existence or Non-Existence of a Disability

"Disability" is a concept with medical, legal and economic aspects. I is intended that the MRP will address only the medical aspects of this concept. The Panel should therefore express its conclusions in medical terms only, and leave it to the Board to consider the medical decisio of the Panel together with the legal and economic aspects of disability.

Thus, if it appears to a Panel that the worker has some symptoms, but there is a doubt whether it should be classified as a "disability", the Panel should simply certify what it has concluded the worker has, together with the functional significance of whatever it is. The Board can then determine whether it should be classified as a "disability".

The problem is most likely to arise with regard to internal disorders, but it can be illustrated by the example of finger amputations. Loss of a full finger is treated as a disability; so is the loss of a substantial portion of a finger. However, as one gets closer to the tip of the finger, a point must be reached at which the loss of tissue is regarded as too slight to be a "disability". Where that line should be drawn is a question of law and policy for the Board to determine.

The problem can also be considered in relation to pain. The symptoms of pain are entirely subjective. A pain may be described by the patient and the only question may be one of credibility. If so, an MRP cannot certify that the conclusion reached by the Board is either right or wrong. If there is no method known to medical science by which to determine the existence or severity of the pain, the Panel could simply certify to that effect. On the other hand, there may be cases where the Panel can, as a matter of medical science, contribute something towards an answer to the existence of pain. For example, the Panel may be able to certify that the pain described by the patient is consistent with clinical symptoms found by the Panel on examination. Or, in another case, the Panel may be able to certify that it cannot find anything to account for the pain described. If the pain exists, the Panel need not concern itself with whether it should be classified as a disability. What the Board needs from the Panel is whether, as people learned in medical science, the Panel members can tell it anything about the existence or severity of the pain beyond what could be determined by the Board listening to the patient and making its own judgement on his credibility.

### (c) Cause of the Disability

Under Section 61(1)(d), an MRP is required to certify as to the cause of the disability. However, "cause" refers to the etiology of the condition. It means cause insofar as it is a matter of medical science, but not cause insofar as it is a matter of moral value judgements, of law, or of non-medical fact.

Suppose, for example, a worker suffers an injury to his hand by catching it in machinery at work. During subsequent medical treatment in hospital he suffers an infection. The infection results in a disability far greater than would have resulted from the original injury. Suppose then that the question raised is whether the ultimate disability was "caused" by the work injury. That is a broad issue that really incorporates several questions, some medical and some non-medical. The responsibility of the Panel in a case of this kind is to consider whether the Board has arrived at correct conclusions on the medical aspects of the matter, i.e. correct conclusions on how and where the infection was contracted and the medical significance of the infection. However, whether the consequences of the infection should be treated as consequences of the original injury for compensation purposes is a question of law and policy that the Board must decide for itself.

## 11. MEDICAL DISPUTE CONCERNING TWO SPECIALTY TYPES

It may happen that an issue will arise in an appeal which is not specifically within the specialists' area of expertise. For example, a Panel which includes two orthopaedic surgeons may consider that the Issues require consideration from a psychological perspective.

The scope of the Medical Review Panel's consideration of the issues before it is not necessarily limited to the area of special expertise of its members. This is a matter for the Panel itself to determine. It is open to the Panel in such cases to either restrict its consideration to the physical aspects of the claimant's injury, or to proceed to consider both the physical and psychological aspects. The Panel may, if it considers that this would be helpful, obtain a consultation report from a specialist in a different specialty (i.e. psychiatry). This may be particularly desirable if there are no reports already available concerning the worker from a specialist in the other area of expertise. The ultimate decision, however, would have to be made by the Panel itself.

If a Medical Review Panel restricted its consideration to the physical aspects of the claimant's injury, the task of considering the psychological aspects would be left for the Board to consider as a separate matter. On the other hand, if the Panel includes the psychological aspects of the worker's injury in its consideration, then the Panel's decision is binding on the Board concerning both the physical and psychological aspects of the injury. In order to ensure that the Board gives proper effect to the findings of the Medical Review Panel, the scope of the Panel's inquiry should be made clear in its Certificate. To avoid any ambiguity, this could be accomplished by stating in the opening paragraph or preamble in the Certificate as follows:

(a) The Medical Review Panel restricted its consideration to the physical aspects of the worker's injury, OR,

(b) The Medical Review Panel included in its consideration both the physical and psychological aspects of the claimant's injury.

## 12. TREATMENT

It is not normally the responsibility of an MRP to advise on treatment. The one area of exception to this is in the Panel's consideration as to whether or not the worker's condition is permanent. It is appropriate within this context for the Panel to indicate if, for example, the worker's condition is at present essentially stable, but that there is a possibility or likelihood of improvement with appropriate treatment.

As the Panel's Certificate is intended to contain the Panel's legally binding conclusions, if the Panel wishes to provide specific recommendations for treatment, this would best be contained in the Panel's accompanying narrative report.

## 13. ASSESSING PERMANENT DISABILITY

### (a) Stabilization

In determining a claimant's entitlement, the Board needs to know on a medical basis whether the claimant's condition is temporary in nature, or whether it has stabilized or plateaued and is no longer improving or deteriorating. (Wage loss benefits are paid during periods of "temporary" disability, while pension benefits may be payable for any "permanent" disability once the claimant has recovered from the acute phase of his injury and his remaining residual disability has stabilized or his recovery has plateaued). On this latter point, the Board would still consider a worker's condition essentially stable or permanent if any further changes would likely occur over more than twelve months. The Board's procedures allow for reevaluation of permanent disability awards where there is a change in the level of the worker's disability. For example, a claimant may be reassessed to ascertain the extent of a gradual increase in his disability on a long term basis.

A Medical Review Panel's Certificate is not binding into the future with respect to the level of a claimant's permanent disability. It remains open to the Board to consider whether there is medical evidence to show that the worker's disability has either improved or deteriorated subsequent to the Medical Review Panel's decision.

### (b) Percentage of Disability

A Medical Review Panel is prohibited by section 61(1)(c) and (e) of the Act from stating its findings as to the nature and extent of the worker's disability in terms of a percentage of disability of the whole body. (Obviously, this prohibition on the use of percentages does not apply to the Panel's consideration of the extent to which there were different causes of a worker's disability.) The reason for the prohibition on a Medical Review Panel stating its findings in terms of a percentage of total disability is that the calculation of such percentages involves consideration of both medical and nonmedical factors.

A Medical Review Panel has jurisdiction to certify to the Board concerning the medical aspects of the worker's permanent disability. This includes the date the worker's condition stabilized, and the extent of any residual impairment of function. A Panel may determine the measurable impairment of function of a worker, with reference to a restriction in range of joint movement, a loss of muscle power or sensory loss of a limb, or other medical findings. It is the Board's responsibility to determine the economic consequences of such a restriction for pension purposes.

In other words, the general issue for a Medical Review Panel in such a case is whether the Board arrived at correct medical conclusions before it started considering the percentage rate.

### (c) Employability/Fitness for Particular Jobs

Similarly, a Medical Review Panel does not have the jurisdiction to determine whether a worker is capable of performing certain "jobs". A finding of fitness or disability with respect to a particular job requires factual findings as to the requirements of the job. There may be factual disputes concerning the requirements of a particular job. While a worker may be disabled from performing his former job as he previously did it, it is sometimes possible to modify the physical requirements of the job so that the worker is capable of returning to work in the same occupation. It is appropriate for a Medical Review Panel to specify the medical limitations or impairment of function suffered by a worker. It is then a matter within the jurisdiction of the Board to determine which job or jobs the worker is capable of performing, taking into account the conclusive and binding findings by the Medical Review Panel concerning the claimant's medical impairment. The findings of the Medical Review Panel are then of far greater application than if it based its entire decision on a narrow set of criteria for certain specified jobs (which might, in any event, be capable of modification in a particular work setting).

### (d) Permanent Total Disability

The basis for the statutory prohibition on a Medical Review Panel certifying as to a percentage of disability of the whole body is that this would necessitate the Medical Review Panel considering the non-medical factors which are involved in assessing such a percentage. The intent of the statutory provision is that in certifying as to disability the Panel must restrict itself to the medical factors, leaving it open to the Board to consider those of a non-medical nature.

The difficulty with a finding of "permanent total disability" is that it seems to preclude the Board from considering these other factors. It creates an expectation that there should be a pension award of 100% of total, even though the Medical Review Panel is prohibited from making such a percentage finding.

In addition, a finding of permanent total disability raises a concern as to whether the Medical Review Panel based its conclusion on issues as to "employability" rather than strictly on the claimant's medical impairment. As outlined above, there are two distinct elements in a determination that a worker is or is not fit to perform a particular job or occupation. There are, first, the physical requirements of the job and, second, the worker's capability of performing those requirements. The first of these is nonmedical in nature and therefore outside the jurisdiction of the Medical Review Panel. The second is a medical matter within the jurisdiction of the Medical Review Panel.

It is possible for a Medical Review Panel to determine on a strictly medical basis that a worker is permanently totally disabled (i.e. in the sense that the worker is suffering from such a degree of impairment that he is medically incapable of functioning in any capacity). If such a finding is being considered, care must taken to ensure that this is on a strictly medical basis rather than incorporating a decision as to the claimant's disability on a percentage basis, or a decision as to the worker's employability.

## 14. RECONSIDERATION

The Act provides that the conclusion of an MRP is conclusive and is binding on the Board. As long as the Certificate of the Panel deals entirely with medical matters, therefore, it is binding on the Board and it is not subject to reconsideration at the Board.

Sometimes, however, a situation arises in which there does appear to be good grounds for reconsideration. For example, the worker may have had surgery since the Panel decision and the surgery may have produced fresh evidence on the medical problem. Even in that situation, the Board does not consider that it has authority to set aside the decision of a Panel. However, the Board might ask a Panel to reconsider the matter and issue a fresh certificate.

## 15. FEES

### (a) General

The fees payable in connection with Medical Review Panels, effective January 1, 1991 are as follows:

| | |
|---|---|
| Chairman | $127.82 per hour |
| Specialists | $426.34 per appeal** |
| Stenographic fee | $ 64.00 per appeal |

**An additional fee of $93.76 per hour is paid to a specialist where the time taken on an appeal, including travelling time, exceeds 3.5 hours, up to a maximum of a further 4.5 hours (maximum payment $848.26).

### (b) Cancellation of Panel

If a Panel is cancelled with less than 48 hours notice, the specialists will receive 84% of the flat fee ($358.13).
The Chairman will receive payment for the time actually spent in preparation, and an additional two hours for the time which had been set for the Panel.

### (c) Reconvening

Specialist - A specialist will receive one half the flat fee (i.e. $213.17) if the reconvening takes less than 1.5 hours, excluding travel time. A specialist will receive the normal fee as set out in (a) if the reconvening exceeds 1.5 hours.
Chairman - The Chairman will receive the hourly rate for time spent in a reconvening.
Stenographic fee - No additional stenographic fee is paid on a reconvening.

(d) Pre-Panel Examination by Specialist

No separate fee is normally payable for a pre-Panel examination. The time spent for this purpose should be included in calculating the total time spent in connection with the examination. As specified in (a), an additional fee of $93.76 per hour is payable if the total time taken exceeds 3.5 hours.

It is recognized that pre-Panel examinations may be desirable where special equipment is needed (e.g. opthalmological, otolaryngological), or in psychiatric examinations. The specialist may in such cases bill either on an hourly basis for the total examination as described above, or on the basis of the following fee items:

| | |
|---|---|
| Psychiatry | 0610 |
| Ophthalmology | 2010 |
| Otolaryngology | 2510 |

If the specialist does not bill on an hourly basis, his account will automatically be paid on the basis of the flat rate fee and the fee item specified for the pre-Panel examination.

(e) Ombudsman

The Chairman will be paid his normal hourly rate for responding to inquiries from the Ombudsman.

## APPENDIX A

## INFORMATION FOR THE ASSISTANCE OF A CHAIRMAN'S ASSISTANT

The following information is intended to provide assistance to a Medical Review Panel Chairman's assistant.

1. Assignment of Panel to Chairman

   Upon receipt of acceptance of nomination forms from the two selected specialists, our scheduling clerk will be in touch with you to see if your Chairman is able to accept the appointment to the Panel at a mutually convenient time.

2. Advice to Claimant

   As soon as the examination date is arranged, the Board will notify the claimant by letter of the date, with copies to each of the doctors' offices. The Board will also contact the claimant concerning transportation arrangements.

3. Telephone Confirmation from Claimant

   This step is very important. Approximately one month before the Panel date, the Board will confirm the date in a letter to the claimant. This letter is sent to the claimant on the Panel Chairman's letterhead and is signed by our office on behalf of the Chairman. The claimant is asked in that letter to confirm with the Chairman's office that he will be attending the Panel. If you do not hear from the claimant, please telephone him for confirmation that he will be attending. Alternatively, if you have problems reaching the claimant, please ask the appropriate Appeals Clerk for assistance:
   Claimants with last name beginning in A-G = Margaret Shea
   H-O = Anne Toews
   P-Z = Lisa Dickson
   Telephone: 276-3122 or 276-3067

4. Medical Records

   The claimant's medical records will be delivered to the Panel Chairman's office approximately two weeks prior to the Panel (unless the Chairman requests earlier delivery).

5. Certificate and Report

   When the Chairman has completed the Certificate and Narrative Report, it should be mailed to the two specialists, in turn, for review and signature. Please photocopy this material before mailing it in case it is lost in the mail. It would also be helpful if you make a note of when and to whom you mail it, in order to keep track of its location.

6. Return of Medical Records

When the Chairman is finished with the claimant's medical records, please contact an Appeals Clerk who will arrange for the material to be collected from your office. Please ensure that x-rays are replaced in their respective envelopes.

7. Accounts

After a Chairman's work on a Panel is completed, his account should be sent to the Board, calculated on an hourly basis.

Address: Workers' Compensation Board
Medical Review Panels
6951 Westminster Highway
Richmond, B.C.
V7C 1C6.

Telephone: 276-3122 or 276-3067
Claimants may telephone the Board toll-free within B.C. at 1-800-972-9972.
Departmental Fax Number: 276-3349

# APPENDIX 10.2

## MEDICAL REVIEW PANELS: AN OVERVIEW FOR THE ASSISTANCE OF NEW MEDICAL REVIEW PANEL SPECIALISTS.

### INTRODUCTION

An appeal to a Medical Review Panel Department may be initiated by a worker, employer or former employer and the Appeal Division or the Board may refer a worker for examination by a Panel. The appeal may follow a medical decision or finding by a Board Officer, the Workers' Compensation Review Board or the Appeal Division. A dependant of a deceased worker may also request a Medical Review Panel inquiry into the cause of the worker's death.

Before a worker is referred to a Medical Review Panel for examination, a physician must:

a) certify that in the opinion of the physician there is a bona fide medical dispute to be resolved;

and

b) state sufficient particulars to define the question in issue.

Medical Review Panels sit independently of the Board and are comprised of a Chairman and two specialists. As one of the specialists eligible to serve on Medical Review Panels, your service is dependent on your agreement to accept a nomination (by the worker or employer) in a particular case. In each case, the Medical Review Panel Department writes to the specialist nominated and provides a form letter for the specialist's use to either accept or decline each nomination.

### MEDICAL REVIEW PANEL DEPARTMENT:

The Medical Review Panel Department staff as of February 6, 1992 are:

| | |
|---|---|
| Registrar: | Dr. Leonard C. Jenkins |
| Manager: | Judy Olson |
| Medical Appeals Officers: | Kris Newman |
| | Dianna Brett |
| | Bev Harwood |
| Medical Appeals Clerks: | Lisa Dickson |
| | Barb Charron |
| | Faye Mykytiw |
| | Helen Ukranitz |
| Panel Scheduling Clerk: | Francine McCullough |

## OUTLINE OF WORKERS COMPENSATION SYSTEM

### (a) Objects of Workers Compensation Act

The Workers Compensation Act has two main objects:

1. The prevention of occupational injuries and disease, and
2. The payment of compensation for occupational injuries and diseases which have occurred.

The Medical Review Panel Department is concerned solely with the second of these objectives.

### (b) Eligibility For Compensation

In order to have a valid claim for compensation, the following requirements must be met:

1. An application for compensation must be made by a worker or dependant of a deceased worker.

2. The worker must have been employed in an industry covered by Part 1 of the Act. Some industries are excluded from coverage, for example, banks and insurance.

3. The worker must suffer personal injury or death arising out of and in the course of his employment or disablement or death caused by an "industrial disease" due to the nature of his employment. Only diseases designated as such by the Board are "industrial diseases."

The existence of a pre-existing condition is not a bar to a claim being accepted, but the Board may apportion its responsibility in certain circumstances, notably when the previous condition was disabling.

### (c) Type of Compensation

The types of compensation payable are:

### 1. Wage Loss Benefits For "Temporary Total" or "Temporary Partial Disability."

These payments cover the acute phase of recovery following the injury or disease, and terminate when the worker recovers or his condition becomes permanent or stabilizes. They may also be paid if, following an initial recovery or stabilization, the worker suffers a recurrence of disease. The amount of full wage loss benefits is 75% of the worker's pre-injury earnings, up to the statutory maximum (now $48,000).

### 2. Permanent Partial Or Total Disability Awards

These are payable after the temporary disability stabilizes and wage loss benefits are terminated. There are two types of award:

i) Physical impairment awards based on the loss of body function of the worker. A percentage of disability is assessed which is applied to 75% of the worker's pre-injury earnings up to the maximum. The award may be granted as a monthly pension or lump sum.

ii) Loss of earnings awards where the worker cannot return to his previous work. An assessment is made of employment which is suitable for the worker's impairment and likely over the long term to be available to the worker. If the difference between the earnings in this employment and the pre-injury earnings (up to the maximum) exceeds the physical impairment award, an additional award is granted equal to 75% of the difference.

A permanent disability may be reassessed if there is a change in the permanent disability following the initial pension assessment.

3. Medical Aid

The Board pays for all medical treatment resulting from the injury.

4. Vocational Rehabilitation

The Board has a discretion to provide retraining or other assistance needed to enable a disabled worker to find alternative employment.

5. Where a dependant of a deceased worker is claiming, benefits vary according to the age, number and type of dependant. A lump sum or monthly pension may be payable.

(d) Adjudication/Appeals Procedures

1. All initial decisions on claims are made by a Claims Adjudicator in the Claims Department.

2. The decision of the Claims Adjudicator is subject to a managerial review within the Claims Department, upon request.

3. From the decision of the Claims Adjudicator or Manager, there is a choice of appeal. The normal route is an appeal to the Workers' Compensation Review Board within 90 days. This appeal may be taken on any issue affecting a worker. The alternative is an appeal to the Medical Review Panel within 90 days where the issue is a medical one.

4. After a Review Board finding, there is an option to appeal to the Appeal Division within 30 days on any issue or to a Medical Review Panel within 90 days on a medical issue.

5. After an Appeal Division decision, the only avenue of appeal is to the Medical Review Panel within 90 days on a medical issue. The Appeal Division has the authority to reconsider their prior decisions.

## CONFLICTS OF INTEREST

Section 59 of the Workers Compensation Act sets out the manner in which the members of a Panel are appointed. It is noted that no specialist may be a member of a Medical Review Panel who:

a. examines workers on behalf of the employer;
b. has treated the worker;
c. has acted as a consultant in the treatment of the worker;
d. is a partner of, or practices medicine together with such specialist,

and there shall not be on the same Panel specialists who are partners or who practice medicine together.

A Chairman or specialist should also decline service on a particular Panel if there might be a possible perception of bias on any other ground.

## ISSUES

On all Medical Review Panel appeals brought by a worker or employer, there will be a specific medical dispute which the Panel is required to resolve. The worker or employer will have submitted a Certificate from a physician, certifying as to the existence of a bona fide medical dispute, and stating with sufficient particulars to define the question(s) in issue. The purpose of the Panel is to resolve this specific dispute.

The Panel is not restricted, however, to resolving the dispute defined by the physician's Certificate. Rather, this Certificate is the key which unlocks the door to the Medical Review Panel inquiry. The Panel is required to certify to the Board on a list of different issues, and the Panel must reach its own conclusions on all medical issues before it. The list of issues is drafted by a Medical Appeals Officer, and is attached to the Statement of Foundational Non-Medical Facts provided to the Medical Review Panel. The Panel's Certificate should answer all the questions posed, even if it is simply to state that the particular issue is not applicable, or has been dealt with elsewhere in the Certificate.

It is not open to the Panel to indicate that it is unable to come to a decision. This would amount to the Panel declining to exercise its jurisdiction. If the inability to reach a conclusion is due to a lack of medical or factual evidence, the Panel may wish to consider whether it should pursue such evidence, possibly with the Board's assistance.

## JURISDICTION

A Medical Review Panel has ultimate jurisdiction to determine a medical question. A Medical Review Panel has no jurisdiction to determine a factual or legal question, or questions as to compensation entitlement.

The Panel's Certificate must be stated in medical terms without reference to the compensation consequences this might have for the worker or employer. For example, if a Panel considers the worker to have been disabled for a longer period of time than the Board has recognized, the Panel should simply state this in medical terms as to the relevant time frame and extent of disability. It is inappropriate for a Panel to comment with respect to matters of compensation entitlement such as wage loss benefits or pension benefits. (Of course, the Panel members may well be aware of the probable significance of their medical findings on the questions of compensation entitlement, but this is essentially irrelevant to the Panel's medical decision making).

As the Panel only has jurisdiction to consider the medical issues, it must accept the Board's decisions on non-medical facts as binding (see "Non-Medical Facts", following).

## NON-MEDICAL FACTS

As a Medical Review Panel only has jurisdiction to resolve medical issues, the Board prepares a Statement of Foundational
Non-Medical Facts which provides the Panel with the factual background of a claim. The Board's practice is to prepare a Statement of Non-Medical Facts for all cases going to a Panel.

The Panel must accept the findings of fact in the Statement as being correct. If it appears to the Panel that anything in the Statement is significantly wrong or if additional factual information is required for the Panel to reach a decision, the matter should be referred back to the Board. If the factual dispute has already been considered by the Board and a decision has been rendered on the factual issue, that decision must be accepted by the Panel. However, the Panel must go on to reach its own conclusions about the medical significance of the factual findings.

The Statement of Foundational Non-Medical Facts and Issues are provided to Medical Review Panel members approximately two weeks prior to the examination date.

## PROCEDURE

### A. Determined by Panel

A Medical Review Panel has the authority to determine its own procedure. The Panel may exercise discretion to receive and accept evidence which is felt to be fit and proper or essential to the medical problem to be decided.

### B. Subpoena

A Medical Review Panel has the legal authority to issue a subpoena to compel the attendance of a witness or the production of records (including a treating physician or his records). A Panel may also request the assistance of the Board in obtaining additional records or information.

### C. Examination

Except in cases of fatal claims, the Workers Compensation Act requires that the Panel shall proceed by examination of the worker. It is left to the Panel to determine what kind of examination is appropriate, but there must in every case be an examination. If the worker has fully recovered, it may be that the Panel will have to base its decision primarily on the available medical records, but some examination is still legally necessary.

D. Representatives

If the worker wishes to have someone accompany him/her for the examination, whether the other person should be present is something for the Panel to determine. In any event, the Board has no objections.

If the worker brings a representative, and if the Panel concludes that the worker should be examined in the absence of the representative, it is a most desirable practice for the Panel to indicate that it will listen to anything that the representatives may wish to say either before or after the examination.

E. Interpreters

If the Board considers it necessary, it will arrange for an interpreter to be present at the time of a Panel examination. The decisions as to whether or not the interpreter is admitted to the examination, or how the interpretation services are utilized, remain the Panel's. Similarly, the worker may bring a friend or family member as an interpreter. In either case, the extent of the interpreter's involvement is for the Panel to determine.

F. Additional Medical Testing

If the Panel requires additional medical information, the Panel is free to reach its own conclusions about how the information should be obtained. For example, if the Panel requires an additional x-ray or laboratory test, this can be arranged by the Panel, or the Panel can ask for it to be arranged by the Medical Review Panel Department, or it can be done in whatever manner the Panel thinks appropriate.

The Panel may also obtain a consultation report from a specialist in another specialty, if necessary. A special consultation fee would be payable which would depend on the nature of the report requested (i.e. consultation report or medical/legal report). The Panel may request such a consultation either before or after its own examination, prior to issuing a Certificate. For example, a Panel may request a report from a psychologist, an epidemiologist, or a person engaged in specialized research or testing, etc., as the Panel considers necessary to its decision.

## PANEL CONCLUSIONS

A. Certificate

The Panel is required to produce a Certificate, in which the Panel certifies to the Board its conclusions on the issues posed. The conclusions of a Medical Review Panel contained in a valid Certificate are legally binding on the Board. The Certificate is normally signed by all three Panel members. If there are any differences of opinion, the Chairman certifies as to the majority decision of the Panel, which may not necessarily be his own opinion. Copies of the Certificate are forwarded by the Board to the worker, the employer, and their representatives, as well as to the physician whose certificate initiated the appeal.

## B. Report

There is no legal requirement that an accompanying Narrative Report be prepared, but it is a usual practice. It is preferred that the Narrative Report be sent to the Board at the same time as the Certificate, and that it be signed by all three Panel members. A copy of the Narrative Report will be sent by the Board to the physician whose Certificate of bona fide medical dispute initiated the appeal. The worker, employer or their representatives are not provided with copies of this Narrative Report, although it will be disclosed by the Board together with the other records on file if requested in connection with an appeal. Such a report may serve the following purposes:

i. Reasons for Conclusions - The Panel may wish to explain the reasoning behind its conclusions to assist the reader in understanding the decision.

ii. Clarification of Certificate - The Panel may wish to elaborate in greater detail concerning the conclusions contained in the Certificate. This would be of assistance to the Board in implementing the Panel's decision.

iii. Details of Panel's Examination - It is useful for the Panel to record in its report details of the history or statement given by the worker to the Panel, as well as the Panel's findings concerning the physical examination of the worker. This may include an account of the worker's present complaints, past illnesses, family history and personal history. The Panel must ensure, however, that the Statement of Foundational Non-Medical Facts, and not the facts as stated by the worker at the time of the examination, is used as the factual basis for the Panel's medical findings.

iv. Confidentiality - As part of its medical examination the Panel may incidentally diagnose medical conditions unrelated to the issues before the Panel. The report provides a mechanism to convey these findings in confidence to the worker's attending physician. There may be matters which the Panel feels would be medically harmful to communicate to the worker in a Certificate which will be sent to all interested parties. There may be something which the patient should be told, but which should be told to him by the attending physician rather than by simply receiving it in a letter.

v. Record of Information Considered

The Panel may wish briefly to summarize the medical information considered. The Board may in the future receive a request that the Panel be reconvened on the basis of significant new medical evidence, or on the basis that there was significant medical evidence

which was not provided to the Panel. For this purpose, it may be helpful to have a record of the information considered by the Panel. It is not necessary, however, to repeat the contents of the medical records, as these will always be available for reference in the Board's files.

## CLARIFICATION OF CERTIFICATE

As there is a possibility that a Panel may be asked to reconvene in the future after issuing a Certificate, the Panel members should refrain from discussing the case with the worker, employer, Board employees, or any interested party. This will assist in avoiding any future allegation of bias which might disqualify the Panel from considering the matter further.

## CERTIFICATE OF A MEDICAL REVIEW PANEL DEPARTMENT

(a) Degree of Certainty

It is recognized that medical science cannot always provide definitive answers. While in some cases it may be possible to certify a conclusion in terms of something being so or not so, there are many cases in which a conclusion can only be expressed in terms of probabilities. It is expected that the Certificate of a Panel will sometimes express conclusions in terms of probabilities rather than certainty. Panels often use words such as "possible" and "may." Any words or combination of words implying that the chances are 49% or less that there is a causal relationship may be interpreted by the Board to mean that there is insufficient evidence of a link. Board responsibility only results where, at a minimum, the possibilities that there is a causal link are evenly balanced (i.e. 50% or better). It is for this reason that there is a note at the bottom of all sets of issues referring to alternative possibilities. The Board has no objection to the use of qualifying phrases, given that it is recognized that medicine is not an exact science; however, the significance of these qualifying words should not be forgotten when Certificates are drafted.

(b) Existence or Non-Existence of a Disability

"Disability" is a concept with medical, legal and economic aspects. It is intended that the Medical Review Panel will address only the medical aspects of this concept. The Panel should therefore express its conclusions in medical terms only, and leave it to the Board to consider the medical decision of the Panel together with the legal and economic aspects of disability.

(c) Cause of the Disability

Under Section 61(1)(d), an Medical Review Panel is required to certify as to the cause of the disability. However, "cause" refers to the etiology of the condition. It means cause insofar as it is a matter of medical science, but not cause insofar as it is a matter of moral value judgements, of law, or of non-medical fact.

## MEDICAL DISPUTE CONCERNING TWO SPECIALTY TYPES

It may happen that an issue will arise in an appeal which is not specifically within the specialists' area of expertise. For example, a Panel of two orthopaedic surgeons may conclude that the issues require consideration from a psychological perspective.

The scope of the Medical Review Panel's consideration of the issues before it is not necessarily limited to the area of special expertise of its members. This is a matter for the Panel itself to determine. It is open to the Panel in such cases to either restrict its consideration to the physical aspects of the worker's injury, or to proceed to consider both the physical and psychological aspects. The Panel may, if it considers that this would be helpful, obtain a consultation report from a specialist in a different specialty (i.e. psychiatry). This may be particularly desirable if there are no reports already available concerning the worker from a specialist in the other area of expertise. The ultimate decision, however, would have to be made by the Panel itself.

## TREATMENT

It is not normally the responsibility of an Medical Review Panel to advise on treatment. The one area of exception to this is in the Panel's consideration as to whether or not the worker's condition is permanent. It is appropriate within this context for the Panel to indicate if, for example, the worker's condition is at present essentially stable, but that there is a possibility or likelihood of improvement with appropriate treatment.

As the Panel's Certificate is intended to contain the Panel's legally binding conclusions, if the Panel wishes to provide specific recommendations for treatment, this would be best contained in the Panel's accompanying narrative report.

## ASSESSING PERMANENT DISABILITY

### (a) Stabilization

In determining a worker's entitlement, the Board needs to know on a medical basis whether the worker's condition is temporary in nature, or whether it has stabilized or plateaued and is no longer improving or deteriorating. (Wage loss benefits are paid during periods of "temporary" disability, while pension benefits may be payable for any "permanent" disability once the worker has recovered from the acute phase of his injury and his remaining residual disability has stabilized or his recovery has plateaued). On this latter point, the Board would still consider a worker's condition essentially stable or permanent if any further changes would likely occur over more than twelve months. The Board's procedures allow for re-evaluation of permanent disability awards where there is a change in the level of the worker's disability. For example, a worker may be reassessed to ascertain the extent of a gradual increase in his disability on a long term basis.

A Medical Review Panel's Certificate is not binding into the future with respect to the level of a worker's permanent disability. It remains open to the Board to consider whether there is medical evidence to show that the worker's disability has either improved or deteriorated subsequent to the Medical Review Panel Department's decision.

### (b) Percentage of Disability

A Medical Review Panel has jurisdiction to certify to the Board concerning the medical aspects of the worker's permanent disability. This includes the date the worker's condition stabilized, and the extent of any residual impairment of function. A Panel may determine the measurable impairment of function of a worker, with reference to a restriction in range of joint movement, a loss of muscle power or sensory loss of a limb, or other medical findings. It is the Board's responsibility to determine the economic consequences of such a restriction for pension purposes. In other words, the general issue for a Medical Review Panel in such a case is whether the Board arrived at correct medical conclusions before it started considering the percentage rate.

(c) Employability/Fitness for Particular Jobs

Similarly, a Medical Review Panel does not have the jurisdiction to determine whether a worker is capable of performing certain "jobs." A finding of fitness or disability with respect to a particular job requires factual findings as to the requirements of the job. There may be factual disputes concerning the requirements of a particular job. While a worker may be disabled from performing his former job as he previously did it, it is sometimes possible to modify the physical requirements of the job so that the worker is capable of returning to work in the same occupation. It is appropriate for a Medical Review Panel to specify the medical limitations or impairment of function suffered by a worker. It is then a matter within the jurisdiction of the Board to determine which job or jobs the worker is capable of performing, taking into account the conclusive and binding findings by the Medical Review Panel concerning the worker's medical impairment. The findings of the Medical Review Panel are then of far greater application than if it based its entire decision on a narrow set of criteria for certain specified jobs (which might, in any event, be able to be modified in a particular work setting).

(d) Permanent Total Disability

The basis for the statutory prohibition on a Medical Review Panel certifying as to a percentage of disability of the whole body is that this would necessitate the Medical Review Panel considering the non-medical factors which are involved in assessing such a percentage. The intent of the statutory provision is that in certifying as to the disability the Panel must restrict itself to the medical factors, leaving it open to the Board to consider those of a non-medical nature.

## SCHEDULING OF PANEL EXAMINATION DATES

The Medical Review Panel Chairmen are assigned to each appeal on a rotational basis, according to their individual schedules. The Panel Scheduling Clerk from the Medical Review Panel Department contacts the Chairman and the two specialists who have accepted nominations, in order to schedule a suitable time and date for the Medical Review Panel examination.

In order to facilitate the scheduling of the examination date, the appointment of a Chairman for a particular Panel may be rescinded and the Panel reassigned to another Chairman. Also, if the specialists nominated have conflicting schedules, it may be necessary to cancel their nomination in order to arrive at a mutually convenient Panel date for all concerned.

As soon as the examination date is scheduled, the Medical Review Department will notify the worker of the date by letter, with a copy to all interested parties.

Approximately one month prior to the Medical Review Panel examination date, the Medical Review Panel Department will confirm the date in a letter to the worker, on behalf of the Panel Chairman. If necessary, a Medical Appeals Clerk from the Medical Review Panel Department will make transportation and accommodation arrangements for the worker and for specialists who reside outside the Lower Mainland.

## LOCATION OF PANEL EXAMINATIONS

Medical Review Panel examinations are customarily held in the office of the Panel Chairman and normally commence at 3:30 p.m. or 4:00 p.m. The Panel might wish to schedule the examination in the office of one of the specialists if the examination involves the use of special equipment. This is a matter for the Panel to determine. A Panel might even be asked to examine a worker in hospital, if he was not fit to travel.

## MEDICAL RECORDS

The Board will provide the Medical Review Panel with all of the worker's medical records from relevant claim files. The Board will also try to obtain original CT scans and x-rays for review by the Panel. The Board does not normally provide the Panel with the worker's non-medical records from the claim file, although these will be provided if requested. The worker's medical records will be delivered to the Panel Chairman's office two or three weeks prior to the Panel date.

## FEES PAYABLE

The flat fee payable to specialists for service on a Medical Review Panel held on and after January 1, 1992 is $444.99. If a Panel is cancelled with less than 48 hours notice, you will receive 84% of the full fee ($373.79).

In addition to the flat fee, a fee of $97.86 per hour is payable when the time taken on an appeal (including travelling time) exceeds 3-1/2 hours, up to a maximum of a further 4 1/2 hours. If the total time taken on an appeal is eight hours or more, the maximum fee payable is $885.36. (If a specialist conducts an examination prior to the Panel examination, the time involved should be included in the total time taken on an appeal as long as no separate fee is payable).

If it is necessary to reconvene a Medical Review Panel after the Panel's Certificate has been submitted to the Board, one-half of the flat fee ($222.50) is payable if the reconvening takes less than 1-1/2 hours and the full flat fee is payable if the reconvening exceeds 1-1/2 hours.

After the Panel examination is held, please send your itemized account to the attention of **"Medical Appeals Clerk, Medical Review Panel Department, Workers' Compensation Board, Box 5350, Vancouver, B.C., V6B 5L5"** and include any original receipts for accommodation, travel, parking expenses etc.

# APPENDIX 11

## MEMORANDUM AND GUIDELINES ON THE IMPLEMENTATION OF MRP CERTIFICATES.

### MEMORANDUM

| | |
|---|---|
| **To:** | Claims Adjudicators |
| **From:** | Len T. McNeely |
| **Date:** | July 8, 1992 |
| **Subject:** | Implementation o[illegible]R.P. Certificates |
| **cc:** | Compensation Services Management<br>Mr. James E. Dorsey<br>Mr. Kenneth M. Dye<br>Ms. Connie Munro<br>Internal Audit<br>Employers' Adviser<br>Workers' Adviser<br>Ombudsman |

Prior to June 3, 1991, all Medical Review Panel certificates were reviewed by a lawyer in the Appeals Administration Department before being referred to the Claims Adjudicator. The Appeals Administrator determined whether there was any question arising as to the clarity of the certificate and the authority of the Panel. Since that date, the practice has been to refer certificates directly to the Claims Adjudicator and for the Claims Adjudicator to consult his or her manager if there are any difficulties with the certificate.

Experience since June 3, 1991, has indicated the need for a more specialized process within the Compensation Services Division to deal with questions arising from Medical Review Panel certificates. However, the whole Medical Review Panel process is currently the subject of a review by the Registrar of Medical Review Panels, Dr. Jenkins. His recommendations may result in changes to the manner in which Medical Review Panel certificates are implemented.

Subject to what may result from Dr. Jenkins' review, the procedures set out below and the attached guidelines have been developed.

1. Certificates will continue to be forwarded by the Medical Review Panel Section directly to the Claims Adjudicator. The Claims Adjudicator will proceed with implementation of the certificate.

Implementation of M.R.P. Certificates

2. If a Claims Adjudicator feels that there is a serious problem with a certificate and would like assistance, the Manager should be immediately consulted. This may be followed by informal consultation with other persons having experience in this area.

3. Failing resolution through the above process, the Claims Adjudicator may, with the approval of the Manager, formally refer the certificate to an Executive Policy Adviser, Research and Policy Section. This should only occur in exceptional cases where one of the following situations exists:

    A. The certificate contains an inconsistency or ambiguity for which clarification from the Panel is required or desirable;

    B. The certificate contains decisions on areas outside the authority of the Panel which cannot be accepted;

    C. Significant new evidence has been received which indicates that the Panel made a fundamental mistake and should be reconvened (See #103.58 of **Manual**).

4. The Executive Policy Adviser will review the referral and, where appropriate, invite comment from the worker and employer or other party concerned. The Executive Policy Adviser may then forward the matter to the Vice-President, Compensation Services Division for decision.

5. The above process should also be followed if a worker, employer, or the Ombudsman is disputing whether the situations in paragraph 3 exist.

6. Any request for the President to exercise his authority in Section 58(5) to have the claimant examined by a Medical Review Panel should be sent directly to the Vice-President.

7. Attached are some guidelines to be used in applying these procedures.

Len T. McNeely,
Vice-President
Compensation Services Division

LTMcN/pdl

## GUIDELINES REGARDING THE IMPLEMENTATION OF

## MEDICAL REVIEW PANEL CERTIFICATES

1. The law and policy concerning the authority of Medical Review Panels, the effect of their certificates, and the obtaining of clarifications and reconsiderations of certificates is set out in Chapter 13 of the **Rehabilitation Services and Claims Manual** (#103.00 to #103.70). It is not intended to repeat what is set out there.
**Certificate Interpretation and Clarification**

2. The Medical Review Panel certificate must be read carefully along with the text of the questions put to the Panel. The aim should be to ascertain the intention of the Panel based on the words used. Claims Adjudicators should be mindful of the words used and not base their decision on conjectures as to what the Medical Review Panel might have meant. Statements made in the accompanying report which are not repeated in the certificate are not binding, though they may assist in interpreting the certificate.

3. The Panel's answer to one or more of the questions put to it may be so unclear or inconsistent with another answer that the intention of the Panel cannot be ascertained. In this situation, the Board may have to request clarification so that the Panel can fulfil its statutory obligation to provide a proper certificate.

**Authority of Panel**

4. A distinction must be made between a decision of the Medical Review Panel and a mere recommendation or suggestion that the Board carry out a certain action, for example, provide further treatment or rehabilitation. While there is no obligation on the Board Officer to carry out the latter, he or she should give strong weight to the Panel's suggestion and consider following it.

5. If a Panel has technically exceeded its authority, for example, by making a finding as to medical treatment or non-medical facts contrary to the decision of the Board, the Board Officer should not automatically refer the matter to the Vice-President. The officer should, if the matter is one within his or her authority, first consider whether the Board's decision on that question should be changed. Alternatively, the Officer should refer the matter to the Officer within the Compensation Services Division who has authority. If the matter is one which has been dealt with by the Review Board or Appeal Division, a referral to the Executive Policy Adviser and Vice-President may be necessary.

6. Panels will occasionally gather evidence that is not in conflict with the non-medical facts accepted by the Board. There is no objection to this. An example of this occurs when, while taking a history from the worker, the Panel obtains more information about the nature of his ongoing symptoms than that in the possession of the Board.

# APPENDIX 12

## ISSUES (DRAFT) SENT TO INTERVIEWEES AND OTHERS

May 29, 1992

Mr. Blake Williams
Director, Workers' Advisors Office
Workers' Compensation Advisory Services
3000 - 8171 Ackroyd Road
Richmond, B.C.
V6Z 3K1

Dear Mr. Williams:

Re: Draft Issues to be Covered in the Report on the Medical Review Panel Process

In follow-up to our recent meeting, I am enclosing a draft copy of the Issues to be Covered in my report on the Medical Review Panel process. Please note that it is a draft and therefore subject to change to some extent by the feedback of comments that I may receive from you.

The Issues are presented in a series of questions. The answers to these questions will form the basis of the Recommendations in the report.

I have arranged these questions/issues in the order of the natural flow of the Medical Review Panel process, under fifteen (15) subject/process headings.

I look forward to your comments with respect to my list of questions. I would, in particular, appreciate knowing whether I have identified all the issues which need to be addressed. If you also wish to respond to any of the questions/issues, you are welcome to do so. I am advised, however, that you will have the opportunity to make submissions to the Governors, and to comment on my recommendations, as part of the Governors' consideration of my report.

In some instances, I met with you as a group. If such was the case, I would appreciate you coordinating the replies as they would then be more meaningfully representative and have greater import.

My schedule mandates that I need your reply by no later than June 30th, 1992, in order to consider your feedback and submit my report to the Governors by the end of August.

I very much appreciate your interest and enjoyed my meeting with you.

Yours very truly,

DR. LEONARD C. JENKINS, M.D., C.M. F.R.C.P.C.
Registrar, Medical Review Panels

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **I. INITIATING A MEDICAL REVIEW PANEL APPEAL** | |
| **A. Claimant's Request** | 1.0 (see [B] Time Limits)<br>Are criteria for a claimant's request clearly stated? |
| **B. Time Limits** | 2.0 Are the time factors relevant? Are they too restricted? |
| | 3.0 Should S.58 of the Act be amended to provide specific authority to waive the appeal time (90 days) in appropriate cases? What are appropriate cases? Where should this authority lie? |
| **C. Physicians Enabling Certificate Establishing a Bona Fide Medical Dispute** | 4.0 What material (evidence) should be available to explain "Medical decision" (or "medical finding") criteria to determine existence of a bona fide medical dispute. |
| | 5.0 Are the Guidelines to physician adequate? If not, how could they be improved? |
| | 6.0 Should the Board be able to reject an enabling certificate? If so on what grounds? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **Initiating a Medical Review Panel Appeal**<br>(cont'd) | 7.0 Should non-physician, health care givers be able to raise an enabling certificate eg. Chiropractors, dentists (oral surgeons), psychologists, etc.? |
| | 8.0 What should the criteria be for accepting a certificate from an out of province physician? |
| | 9.0 Should the criteria for the acceptance of a physicians' Certificate from an employer be different from the criteria for acceptance from a worker? |
| **D. Administrative Decision Making** | 10.0 Why are there decision delays? |
| | 11.0 What can be done to eliminate such delays? (see also 10.0) |
| | 12.0 Who should make the determination as to whether an out of province physicians' certificate will be accepted? (see also 8.0) |
| | 13.0 Who should be responsible for deciding whether a bona fide medical dispute has been established? What does "sufficient particulars to define the question in the issue" mean? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **Initiating a Medical Review Panel Appeal**<br>(cont’d) | 14.0 What additional skills and training are required for a Medical Appeals Officer? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **II. STATEMENT OF FOUNDATIONAL NON-MEDICAL FACTS/ISSUES.** | |
| **A. Non-medical facts** | 1.0 Should the Medical Review Panel (M.R.P.) be bound by the Boards' findings of non-medical facts? |
| | 2.0 How should the M.R.P. deal with "new facts" or "disputed facts" which emerge during the history-taking by the Panel? |
| | 3.0 Who should be responsible for reviewing the file to obtain any additional medical records which might be relevant to the decision in dispute which are not found on the claim file? |
| | 4.0 Should the Panel be provided with the whole claim file or as is the case currently, with the "split" file? |
| | 5.0 Is it necessary for the Board to prepare a Statement in every case? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **Statement of Foundational Non-Medical Facts/Issues** (cont'd) | |
| **B. Issues** | 6.0 Are the guidelines for preparation adequate? |
| | 7.0 Are the questions always specifically and adequately relevant to the issues raised? |
| | 8.0 Are the questions and issues raised too standardized to fairly reflect the issues? |
| | 9.0 Is it necessary for the Board to prepare a statement of issues in every case? (see also 5.0) Should the Panel simply be asked to certify according to their jurisdiction as set out in Section 61? |
| | 10.0 Is it necessary for the M.R.P. to be asked all standard questions in every case? Should S.61(1) be amended? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| III. DESIGNATION OF SPECIALTY | 1.0 Currently the Registrar designates the speciality. Is the process of how this is done, appropriate? |
| | 2.0 Who should have this responsibility? |
| | 3.0 Is there a role for the worker/employer? |
| | 4.0 Do the issues in dispute always clearly lie in one specialty only? If not, how should this be managed? |
| | 5.0 Should there be "dual" panels held where expertise in the different specialties might be required? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **Designation of Specialty**<br>(cont'd) | 6.0 Should the Specialty of occupational health or occupational medicine be used in claims for repetitive strain injuries, exposure to toxic substances, or other injuries with disabilities which fall under this heading? |
| | 7.0 Should M.R.P.s be encouraged to make more use of outside resources and consult with specialists in other areas of medicine, or for example, other non-medical fields, psychologists, epidemiologists? |
| | 8.0 What should a M.R.P. do, when it feels the injury or disability falls outside its specialty? |
| | 9.0 How should 'Chronic Pain Syndrome' (CPS) be handled when designating specialties? Are there other special 'common' medical syndromes that should be reviewed in reference to the M.R.P. process? (see also 10.0, 11.0, 12.0, 13.0 below) |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **Designation of Specialty**<br>(cont'd) | 10.0 Which Specialists are appropriate to constitute a Panel in cases where Chronic Pain or CPS is the predominant issue? |
| | 11.0 Is a panel of organic specialists qualified to make findings with respect to chronic pain or CPS? |
| | 12.0 What is the process of interpretation of M.R.P. Certificates when a Panel's understanding of Chronic Pain and CPS contradicts that of the WCB, the worker, the employer or a representative? |
| | 13.0 (see also V. Appointment Specialists members 6.0) |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **IV. APPOINTMENT OF CHAIRMAN, M.R.P.** | 1.0 Should the appointment be made by the Lieutenant Governor in Council? If not, who should have this authority? |
| | 2.0 Should the combined Special Committee of Physicians and Surgeons of B.C. and the British Columbia Medical Association (BCMA) which currently creates lists of Specialists, be the recommending Committee on Chairman (see following)? (Note that the Act only refers to a "Medical Committee" (S.58(2)) in relation to Specialists). |
| | 3.0 Should appointments remain without term? If not, what should the term be? Five (5) years, renewal subject to review? |
| | 4.0 Should there be a termination process established? If so, what should the guidelines to this procedure be? |
| | 5.0 What qualifications should be required? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **Appointment of Chairman, M.R.P.** (cont'd) | 6.0 Should there be a job description? |
| | 7.0 Should Guidelines of Duties and Functions be more clearly than currently defined? (see attached). |
| | 8.0 Should there be specific educational, training programs, for new appointments and Continuing appointments? If so, what subjects should be covered? |
| | 9.0 Should activities, (conduct of Panels) (Certificates), (narratives) be monitored for quality? How? By Whom? (see also following X. QUALITY ASSURANCE PROGRAM) |
| | 10.0 How is the Community to be assured as to the fairness of the Appointment process? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **Appointment of Chairman, M.R.P.** (cont'd) | 11.0 Should regional/gender considerations be a part of appointment criteria? What should other criteria be considered? |
| | 12.0 Should the Panel Chairman be required to have some knowledge of occupational medicine or industrial worksites? |
| | 13.0 Should there be a process for receiving complaints with respect to M.R.P. Chairmen eg. complaints from specialists with respect to certain panel Chairmen or complaints from workers with respect to their examinations by a certain M.R.P.?<br>(see also V. Appointments, Specialists members)<br>(see also IX. M.R.P. conduct)<br>(see also X. Quality Assurance) |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| V. APPOINTMENT OF SPECIALISTS MEMBERS M.R.P. | 1.0 Is the appointment process of Specialists members of a M.R.P. by a "joint committee" of the College of Physician and Surgeons of B.C. and the BCMA (S.58(2)) appropriate? If not, who should prepare and recommend the lists of specialists? |
| | 2.0 How should "joint Committee" members be selected? |
| | 3.0 Are the numbers of selected Specialists members to a given to a given Specialty adequate? |
| | 4.0 What are the guidelines and criteria used by the "joint committee" for selection of Specialists members for M.R.P.? What should the criteria be? |
| | 5.0 Are Physicians and surgeons in B.C. notified adequately of the opportunity to become a Specialist member of M.R.P.? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **Appointment of Specialists Members**<br>**M.R.P.**<br>(cont'd) | 6.0 Is the composition of a panel always adequate? eg. as to expertise for a given problem, for instance in CPS, psychogenic stress, what safeguards could be put into place? (see also III. Designation of Specialty section) |
| | 7.0 Should non-physician health care givers be able to be appointed to Panels? |
| | 8.0 Does the worker/employer have an adequate role/choice? |
| | 9.0 Is the current list of disqualifications for Specialists members serving on a given panel adequate? What other disqualifications should be provided for? |
| | 10.0 Who should make the nomination of a specialist on behalf of the Board, when the worker is self employed, a partner or member of the firm that is the employer, or where the employer has closed its business in the industry, in which the injury or disability occurred? (the Board is to nominate the Specialist as if it were the employer under Section 59(2). |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **Appointment of Specialists Members M.R.P.** (cont'd) | 11.0 Is it necessary for a nomination to be made by the Minister of Labour, in the event the 8 day period after receiving notice is not met? Should this requirement be amended? (Section 59(4) and (5) |
| | 12.0 Are there delays in the process due to Specialists unavailability? If so, how can these delays be resolved? |
| | 13.0 Should the Specialists list be updated on a regular basis? If so, what mechanisms can be put into place to ensure that regular updating occurs? |

| **SUBJECT/PROCESS** | | **ISSUES (to be covered)** |
|---|---|---|
| **VI. EDUCATION/TRAINING, CHAIRMEN, SPECIALISTS MEMBERS, M.R.P. DEPARTMENT STAFF** | 1.0 | Is current orientation (see attached) for new Chairmen, Specialists members adequate? (See also Appointments Section) |
| | 2.0 | Should the WCB improve Continuing education training for M.R.P. Chairmen, Panel Specialists members, instructing them in relevant compensation issues, terminology, role, and jurisdiction of M.R.P. and any relevant issues?<br>Who should coordinate this? |
| | 3.0 | Should sessions for Chairmen/Specialists members be separate or combined? Should other interested parties be invited, eg. lawyers? |
| | 4.0 | Should there be funding support to Chairmen, Specialists members, MRP Department staff, for attendance at training/educational sessions? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **Education/Training, Chairmen, Specialists members, M.R.P. Department Staff** (cont'd) | 5.0 Should there be a process for bringing together from time to time the MRP Chairmen to discuss common issues?<br>If so, what process should be instituted? |
| | 6.0 Should there be a process for advising the MRP Chairmen as to the results of the examinations of other MRP and keeping the Chairmen generally informed of the decisions of other Panels? |
| | 7.0 Should the M.R.P. Chairmen be provided with copies of Court decisions issued with respect to the M.R.P. process? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **VII. M.R.P. CERTIFICATE** | 1.0 Should there be guidelines for a format?<br>How should they be developed? |
| | 2.0 Should there be monitoring of quality of the certificate?<br>If so, what form should it take?<br>Who is responsible for this? |
| | 3.0 As part of the M.R.P. certificate should reasons be given for the decision? |
| | 4.0 Should there be time limits for panels issuing certificates? |
| | 5.0 What are the processes for managing a need for clarification?<br>Are they now adequate?<br>Should there be criteria and guidelines as to when clarification should be sought?<br>Why should clarification be needed at all?<br>(see also 1.0, 2.0, 3.0 and 13.0) |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| M.R.P. Certificate<br>(cont'd) | 6.0 Are there problems with the Board's interpretation and implementation of certificates? |
| | 7.0 Are there differences in process between the adjudicator requiring clarification to implement the certificate and afterwards when an external party asking for clarification because they dispute the implementation? |
| | 8.0 Is there a need for defining what is meant by "interpretation", "implementation"? |
| | 9.0 Should feedback (eg. to M.R.P., WCB Medical Services) be more effective?<br>Should feedback incorporate how each certificate has been "interpreted" and "implemented"?<br>Will feedback be different for the "MRP" and for the "WCB Medical Services"? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **M.R.P. Certificate**<br>(cont'd) | 10.0 Does the Board have the authority to declare a certificate "null and void" - to declare a certificate beyond the jurisdiction of a Panel? If so, what are the criteria to do so?<br>If not, should the Board have the authority and on what grounds? |
| | 11.0 Is the distribution of the certificate adequate? Should there be any restrictions on this? Are there Access to Information Privacy considerations? |
| | 12.0 What are criteria for requesting reconvening of an M.R.P.? What happens if the criteria are met, but the M.R.P. cannot be reconvened because of the death of the Chairman or a Specialist Member of the Panel? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| M.R.P. Certificate<br>(cont'd) | |
| | 13.0 What happens if new evidence arises after an M.R.P. certificate has been issued? What are criteria of new evidence? Who decides if it is new evidence? |
| | 14.0 Does new evidence impact on the binding nature of the certificate? |
| | 15.0 Should an M.R.P. Certificate be referred back to the Panel for Clarification before a claims decision is made when the certificate is disputed by the appellant's Physicians? |
| | 16.0 How long are M.R.P. Certificates valid for? |

| **SUBJECT/PROCESS** | | **ISSUES (to be covered)** |
|---|---|---|
| **VIII. M.R.P.**<br>**NARRATIVE REPORT** | 1.0 | Is the purpose of the narrative report clear? Are the guidelines adequate? |
| | 2.0 | Are there procedures for clarification of contradictions with the certificate?<br>If not, how should contradictions be resolved? |
| | 3.0 | Is the narrative report legally independent of the certificate? |
| | 4.0 | Should there be a standard form developed for the narrative report in order to ensure consistency? |
| | 5.0 | Should the narrative report be used to provide the reasons for the Panel's decision instead of restating the facts and the evidence, as is done currently? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **M.R.P. Narrative Report**<br>(cont'd) | |
| | 6.0 Should it include an explanation as to why the Panel disagrees with the conclusions of the other doctors who have provided opinions on the claim with a view to providing these other doctors with feedback as to why the Panel has disagreed with their medical conclusions? |
| | 7.0 Should the narrative report be disclosed to the worker with the certificate? Who else should receive the narrative report? eg. interacting groups (see subject XII. M.R.P. Interrelationships) |
| | Should S.61 of the Act then be amended? |
| | Are there Access to Information/ Privacy consideration? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| IX. M.R.P. CONDUCT | 1.0 Should there be guidelines as to the format of procedures involved in the conduct of a M.R.P. by the Panel? |
| | 2.0 Are Chairmen aware of Colleagues' procedures? |
| | 3.0 What should the criteria be for dual Panel formation? |
| | 4.0 Can the Chairman of a M.R.P. recommend? Decide? A second panel is required (as an alternative to seeking an opinion from a specialist in another field?) |
| | 5.0 Guidelines for coordination of 3.0, 4.0? |
| | 6.0 Should representatives be allowed at M.R.P. proceedings? Under what circumstances? What role should they play? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| M.R.P. Conduct (cont'd) | 7.0 Who settles impropriety matters? |
| | 8.0 What is the basis for legal support by the WCB? Will this vary with the degree of autonomy considered appropriate for the M.R.P. process? |
| | 9.0 Should the Panel further investigate a claim? eg. should the Panel visit the work site to familiarize themselves with the worker's activity in question if they consider this necessary?<br>Is there a distinction between "finders of fact" and "finders of medical fact"? |
| | 10.0 To what extent can the Panel accept the evidence of the worker where it is different from that contained in II. The Statement of Foundational Non-Medical Facts? (see also II. A. 1.0, 2.0, 3.0) |
| | 11.0 Are delays in the outcome of the claim due to M.R.P. process inefficiencies at (11.1 - 11.8) and how can those delays be eliminated? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **M.R.P. Conduct**<br>(cont'd) | 11.1 Determining whether the statutory requirements for an appeal (eg. time limits, bona fide medical dispute, etc.) have been complied with? |
| | 11.2 Preparing the file to go to the Panels? |
| | 11.3 Scheduling the examination. |
| | 11.4 Arranging for diagnostic tests, consultations, etc.? |
| | 11.5 Examining the worker and discussing the findings of the claimant? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **M.R.P. Conduct** (cont'd) | 11.6 **Drafting the certificate and narrative and reaching final agreement on the issues?** |
| | 11.7 **Board follow-up questions to the Panel on clarifications?** |
| | 11.8 **Disputes by the worker, employer, or a representative, with respect to the interpretation and implementation of the certificate?** |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **X. M.R.P. QUALITY ASSURANCE** | 1.0 Should there be a quality monitoring process? |

For Chairmen?

For Specialists members?

2.0 What form should this take?

3.0 Who should do the monitoring:

- of the Chairmen?
  - Registrar?
  - BCMA?
  - College of Physicians and Surgeons of B.C.?
  - The Chairmen?

- of Specialists?
  - Chairmen?
  - Registrar?
  - College of Physicians and Surgeons of B.C.?
  - BCMA?
  - Specialists?

- other

4.0 Should training/educational guidelines be developed for chairmen/specialists members?

5.0 Should a quality assurance program be in place for the M.R.P. Department?

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| XI. M.R.P.<br>CERTIFICATE IMPLEMENTATION | 1.0 What are reasons for delay and how can they be minimized? |
| | 2.0 What should the procedures for seeking clarifications be?<br>(see also VII. M.R.P. Certificate 5.0 and 6.0) |
| | 3.0 Is feedback to contributing groups adequate? eg. M.R.P. Chairmen, Specialists Members, M.R.P. Department? |
| | 4.0 Is feedback to the WCB Medical Services Division adequate? |
| | 5.0 What are the consequences of Dispute Resolutions Appeals processes? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **M.R.P. Certificate Implementation (cont'd)** | 6.0 Is the "binding nature" of the M.R.P. Certificate adhered to in practice? If not, how can the "binding nature" of the M.R.P. Certificate be better upheld? |
| | 7.0 Should the Panel Chairmen be advised as to the compensation decision made on a claim after the certificate has been implemented, to ensure that the intention of the Panel has been carried out? |
| | 8.0 If a Chairman considers that the intention of the Panel has not been carried out, what should be done? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **XII. INTER-RELATIONSHIPS WITH GROUPS AND REPRESENTATIVES** | |
| Worker<br>Employer | 1.0 Is feedback/interplay adequate with each of these groups? |
| | 2.0 How can the need for M.R.P. appeals be reduced? eg. How important is failure to medically examine the worker by the Board?<br>Are Compensation Services assessments adequate? |
| Workers' Advisers | |
| Employers' Advisers | 3.0 What are the consequences of the access of these groups on the M.R.P. process? |
| Representatives<br>- Legal<br>- Union | |
| Ombudsman's Office | |
| WCB Advocacy Group | |
| The Community | |
| Appeal Division | |
| Review Board | |
| President, W.C.B. | |
| Compensation Services Division (Including Managerial Review) | |
| Medical Services Division | |
| Occupational Health and Safety Division (Occupational Health Department) | |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| XIII.REGISTRAR, M.R.P. | 1.0 To what extent should the MRP process be "independent" of the Board?<br>eg.<br>- completely external?<br>- partly external? eg. with the Registrar (or other individual) reporting to the Governors, as does the Chief Appeal Commissioner?<br>- a different option? |
| | 2.0 Is there a continuing need for a Registrar, M.R.P.? |
| | 3.0 Should the Registrar be an M.D. or not? |
| | 4.0 What should be the terms of reference/function of the Registrar with particular reference to authority or jurisdiction? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **Registrar, M.R.P.**<br>(cont'd) | |
| | 5.0 Qualifications, required? |
| | 6.0 Should the appointment be full-time or part-time? |
| | 7.0 Should the appointment have a term? Renewable? |
| | 8.0 Should the Registrar be a WCB employee or contracted on a consultative basis? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **XIV M.R.P. ADMINISTRATION** | 1.0 Are Chairmen, Specialists compensated adequately?<br>(see also VI. Training/Education 4.0) |
| | 2.0 Are there enough Medical Appeals Officers (MAOs)? |
| | 3.0 Are there enough Appeals Clerks? |
| | 4.0 Is the secretarial/clerk staffing adequate? |
| | 5.0 Is office technology up to par? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| **M.R.P. Administration**<br>(cont'd) | 6.0 Are resources adequate to provide, for example, meaningful statistical analysis, research activity.<br>eg. chronic pain syndrome impact on M.R.P. functions. |
| | 7.0 Having accepted that a bona fide medical dispute has been defined, where the worker is living outside the province, should the Board pay for the whole journey in advance in every case?<br>What should the Departmental Guidelines be on this? |
| | 8.0 Are there delays due to insufficient resources being applied to the processing of M.R.P. appeals? Are there sufficient administrative resources?<br>Are there sufficient M.R.P. resources? |

| **SUBJECT/PROCESS** | **ISSUES (to be covered)** |
|---|---|
| **M.R.P. Administration**<br>(cont'd) | 9.0 Should there be resources made available for legal counsel to the Registrar? |
| | 10.0 Should there be an Annual Report?<br>If so, should it be public?<br>Who should prepare/be responsible for this report? |

| SUBJECT/PROCESS | ISSUES (to be covered) |
|---|---|
| XV. AMENDMENTS TO THE ACT | 1.0 What amendments are required to Sections 58 - 66 of the Act? |

# APPENDIX 13

## MAILING LIST:
## DRAFT ISSUES SENT FOR COMMENT

Mr. John Weir
British Columbia Federation of Labour
4279 Canada Way
Burnaby, British Columbia, V5G 4P1

Mr. Bob Angus
Angus Qually Howard Consultants Ltd.
140 - 12868 Clarke Place
Richmond, British Columbia, V6V 2H1

Brent Qually
Angus Qually Howard Consultants Ltd.
140 - 12868 Clarke Place
Richmond, British Columbia, V6V 2H1

Peter Howard
Angus Qually Howard Consultants Ltd.
140 - 12868 Clarke Place, Richmond,
British Columbia, V6V 2H1

Mr. Larry Stoffman
Director, U.F.C.W.
4021 Kingsway
Burnaby, British Columbia, V5H 1Y9

Ms. Kathy Sanderson
Director of Provincial Affairs,
Canadian Federation of Independent
Business
Suite 525 - 625 Howe Street,
Vancouver, British Columbia, V6C 2T6

Mr. Ed Zurwick
Mining Association of British Columbia
Box 12540, Suite 860 - 1066 West
Hastings Street,
Vancouver, British Columbia, V6E 3X1

Mr. Mark Olson
Labourers' Membership Services
205 - 3550 Kingsway
Vancouver, British Columbia, V5R 5X4

Ms. Cathy Walker
National Representative, CAIMAW
707 Twelfth Street
New Westminster, British Columbia, V3M
4J7

Dr. Clive Thompson
Assistant Executive Director
British Columbia Medical Association
115 - 1665 West Broadway
Vancouver, British Columbia, V6J 5A4

Dr. David Hunt
Board Medical Advisor
Medical Services Division
Workers' Compensation Board
Level 3,W.C.B.

Dr. Terry Anderson
Health Care & Epidemiology, U.B.C.
5804 Fairview Avenue
Vancouver, British Columbia, V6T 1Z3

Mr. Jack Bibby
Chairman, Review Board
Ste. 200 - 1700 West 75th Avenue
Vancouver, British Columbia, V6P 6G2

Dr. John Sehmer
Chairman, Occupational Medicine
Section
B.C. Medical Association
Ste. 115 - 1665 W. Broadway
Vancouver, British Columbia, V6J 5A4

Mr. Blake Williams,
Director, Workers' Advisors Office
Workers' Compensation Advisory Services
3000 - 8171 Ackroyd Road
Richmond, , British Columbia, V6Z 3K1

Mr. Ray Bozzer
Director, Employers' Advisors Office
Ministry of Labour, Compensation
Advisory Services
4003 - 8171 Ackroyd Road
Richmond, British Columbia V6X 3K1

Ms. Patricia Anderson
Office of the Ombudsman
Room 202 - 1275 West 6th Avenue
Vancouver, British Columbia, V6H 1A6

Mr. James F. Sayre
W.C.B. Advocacy Group, c/o Community
Legal Assistance Society
800 - 1281 West Georgia Street
Vancouver, British Columbia, V6E 3Y2

Mr. Craig Paterson
Paterson & Associates
1406 - 207 West Hastings Street
Vancouver, British Columbia, V6B 1K5

Mr. Dave Robertson
Chairman, Employers Forum to the WCB
Ste 305 - 1208 Wharf Street
Victoria, British Columbia, V8W 3B9

Mr. Dunc Wilkins
Vice-President, Industrial Relations
Business Council of B.C.
810 - 1050 W. Pender Street
Vancouver, British Columbia, V6E 3S7

Mr. Bert Hawrysh
Council of Forest Industries of B.C.
Ste. 1200 - 555 Burrard Street
Vancouver, British Columbia, V7X 1S7

Dr. David Bates
4891 College Highroad
Vancouver, British Columbia, V6T 1G6

Dr. J. Nearing
Acting Director
Occupational Health Department
WCB, Richmond, British Columbia

Dr. W.S. Whitehead
Vice President
Occupational Safety and Health Division
WCB, Richmond, British Columbia

Mr. Nick Attewell
Executive Policy Advisor
Policy & Review Division
WCB, Richmond, British Columbia

Mr. Ed. Bates
Vice-President
Legal Services Division
WCB, Richmond, British Columbia

Dr. Colin Campin
Director
Medical Services Divison
WCB, Richmond, British Columbia

Mr. Ken Dye
President and Chief Executive Officer
WCB, Richmond, British Columbia

Mr. Dick Hurst
Director, Claims (Area Offices)
Compensation Services Divison
WCB, Richmond, British Columbia

Mr. Sam Isaacs
Adjudicator
Compensation Services Division
WCB, Richmond, British Columbia

Ms. Judith Jenkins
Manager
Appeal Division
WCB, Richmond, British Columbia

Mr. Len McNeely
Vice-President
Compensation Services Division
WCB, Richmond, British Columbia

Mr. Herb Morton
Assistant to the Chief Appeal
Commissioner
WCB, Richmond, British Columbia

Ms. Connie Munro
Chief Appeal Commissioner
Appeal Division
WCB, Richmond, British Columbia

Dr. A.I.E. Nichini
Vice-President
Medical Services Divison
WCB, Richmond, British Columbia

Ms. Judy Olson
Senior Medical Appeals Officer
Medical Review Panel Department
WCB, Richmond, British Columbia

Mr. Paul Petrie
Appeal Commissioner Registrar
Appeal Division
WCB, Richmond, British Columbia

Mr. Art Quinn
Executive Policy Advisor
Policy and Review
WCB, Richmond, British Columbia

Mr. Keith Sullivan
Manager
Compensation Services
WCB, Richmond, British Columbia

# APPENDIX 14

## BROCHURE COPY FOR MRP EDUCATION DAY
## MAY 29, 1992

# Medical Review Panel Education Day

Workers' Compensation Board
of British Columbia

6th Floor Boardroom
Friday, May 29th, 1992

WORKERS'
COMPENSATION
BOARD

# MEDICAL REVIEW PANEL

## EDUCATION DAY
**Workers' Compensation Board of British Columbia**
**6th Floor Boardroom**

**Friday, May 29, 1992**

## PROGRAM OUTLINE

| | |
|---|---|
| **0745 - 0810** | Coffee, tea and juice<br>Registration and Precis Handout |

## MORNING SESSIONS:

**Moderator:** Dr. Leonard C. Jenkins

| | |
|---|---|
| **0810 - 0815** | Welcome and Introductory remarks (Dr. L.C. Jenkins) |
| **0815 - 0915** | Recent changes and future directions of Workers' Compensation Board (Mr. James E. Dorsey) |
| **0915 - 1015** | Principles of Natural Justice (Ms. Connie Munro) |
| **1015 - 1030** | Refreshment Break - Coffee, tea & juice |
| **1030 - 1130** | Medical - Legal terminology usage and impact on MRP Certificates (Ms. Janice Hight) |
| **1130 - 1200** | Claims Adjudication Process (Mr. Dick Hurst) |
| **1200 - 1230** | Role of Workers' Compensation Board Physician in MRP Process (Dr. A.I.E. Nichini) |
| **1230 - 1330** | Luncheon Break |

## AFTERNOON SESSIONS:

| | |
|---|---|
| **1330 - 1400** | Update from the Registrar - MRP Statistics and Issues (Dr. Leonard C. Jenkins) |
| **1400 - 1445** | How I Conduct My MRP (Dr. Ian D. Connell) |
| **1445 - 1500** | Refreshment Break - Coffee, tea & juice |
| **1500 - 1600** | Open Forum - Discussion of the Issues Related to the Medical Review Panel Process |
| **1600 - 1615** | Completion of Program Appraisal Forms<br>Suggestions for Future Meetings |

## FACULTY

| | |
|---|---|
| Mr. James E. Dorsey, | Chairman, Board of Governors<br>Workers' Compensation Board of British Columbia |
| Ms. Connie Munro, | Chief Appeals Commissioner, Appeal Division<br>Workers' Compensation Board of British Columbia |
| Ms. Janice Hight, | Counsel, Workers' Advisor<br>Compensation Advisory Services, Ministry of Labour |
| Mr. Dick Hurst, | Director, Claims Area Offices, Compensation Services Division,<br>Workers' Compensation Board of British Columbia |
| Dr. A.I.E. Nichini, | Vice-President, Medical Services Division<br>Workers' Compensation Board of British Columbia |
| Dr. Ian D. Connell, | M.D., F.R.C.P.C., Chairman, Medical Review Panel |
| Dr. Leonard C. Jenkins, | B.A., M.D., C.M., F.R.C.P.C., O.St.J.,<br>Q.M., Professor emeritus, UBC, Registrar, Medical Review Panels |

## OBJECTIVES OF THE PROGRAM

The Medical Review Panel Chairmen have not met as a group since May 1990, and very infrequently prior to that date. There is a need to have an update on significant changes and future directions of the Board, that have a direct bearing on Medical Review Panel Processes and Chairmen's activities. Subjects and processes that are important to the Chairmen that will be covered are Principles of Natural Justice, Medical/Legal Terminology usage and impact on Medical Review Panel Certificates, the Claims Adjudication Process, and identification and open discussion of issues involved in Medical Review Panel procedures and processes.

This program is intended to assist in upgrading the skills of Medical Review Panel Chairmen in their decision making and reporting in the field of Workers' Compensation Occupational and Environmental Health.

Application has been made for Continuing Medical Education Seven (7) Credit Hours, Category one (1).

# APPENDIX 15

## SUMMARY PROGRAM APPRAISAL FORMS

Medical Review Panel Education Day

Friday, May 29, 1992

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12 of 14 Chairmen attended (Dr. P. Allen and Dr. J. Sloan absent)

11 of 12 Responded to the questionaire

## 1.0 CONTENT

### 1.1 Was it relevant?

on a scale of 1 (poor) to 10 (outstanding)

| | |
|---|---|
| The results were | 2 for 7 |
| | 4 for 8 |
| | 2 for 9 |
| | 3 for 10 |

### 1.2 Will it modify your conduct of a MRP?

YES - 4

NO - 0

PARTIALLY - 7

### 1.3 Was it meaningful?

| | |
|---|---|
| The results were | 1 for 6 |
| | 1 for 7 |
| | 4 for 8 |
| | 3 for 9 |
| | 2 for 10 |

## 2.0 FORMAT

### 2.1 Site Satifaction?

| | |
|---|---|
| The results were | 2 for 5 |
| | 3 for 8 |
| | 6 for 10 |

### 2.2 Handout Booklet Quality

| | |
|---|---|
| The results were | 2 for 8 |
| | 2 for 9 |
| | 6 for 10 |
| | 1 no opinion expressed |

### 2.3 Presentations length

about right - 11
(1 - some too long)

### 2.4 One day Program

Too short - 1
about right - 10

## 2.5 OTHER COMMENTS

(i) very useful

(ii) hold once each year

(iii) need 1/2 day for discussion problems - 1 hour not long enough

(iv) excellent introduction program

(v) review of 'Act' as applied to MRP needed

(vi) Work in 'complete isolation' - imperative that we meet more often. Have a consensus of the conduction of the business.

(vii) Well done

(viii) Good start

(ix) Review other issues in future

(x) Let's have similar meetings

(xi) an excellent day, very informative

(xii) excellent program and organization

(xiii) need more time for discussion

(xiv) need specialists input on performance of Chairmen and choice of Chairmen (selection of)

## 3.0 FUTURE PROGRAMS

### 3.1 Where?

Unanimous 11 out of 11 at WCB site.
one suggested Hawaii or Whistler!

appraisal\LCJ\stb

Two suggested Victoria as well.

3.2 When?

Every 6 months - 7
Annually - 3
Quarterly - 1
Spring and Fall
Any day of week

3.3 How often per Annum - (see 3.2)

3.4 Topics you would like to have discussed?

(i) Same things as to-day

(ii) Chronic pain syndrome

(iii) Relationships of pre-existing conditions and compensable injury

(iv) Pension awards and their mechanisms

(v) Selection of Chairmen

(vi) Mechanics of the conduct of an MRP

(vii) Post-traumatic fibromyalgia

(viii) opportunities to discuss problems as they arrive in the Panels

(ix) changes and evaluation on WCB policy on repetitive strain injury.

(x) Billing mechanism

(xi) Implementation of Certificates - feedback, Results, Legal Aspects

3.5 Speakers you would like to have?

(i) Experts on Chonic pain, back ache, new Industrial Diseases

(ii) Panel Specialists
Neurological review
Psychiatric review
Orthopaedic review

(iii) President of the WCB - Ken Dye

(iv) Implementation of certificates

(v) Disability Awards Medical Officers - 2

(vi) Go through a certificate - issue by issue- refine some of the statements and language

(vii) Workers' Advocates - and their impression of MRP process

(viii) Experts on Adjudication

(ix) Experts on Implementation (of certificates)

3.6 Ideas on Format?

(i) To-day was good

(ii) same as to-day - have morning for presentations

(iii) Existing format is good

(iv) have a report from specialists, Workers and Employers Advisers'

(v) Have more panel/open discussion - 2

(vi) Have an MRP Chairman Chair part of the session

(vii) Same as this meeting

(viii) A place for problems to be dealt with.

3.7 Who should attend? (other than Chairmen)

(i) Chaimen and staff

(ii) Various members of Appeals Administration from time to time.

(iii) Speakers

(iv) Guest Specialists

(v) MRP Dept. employees

(vi) Resource people pertinent to topics

(vii) WCB staff involved in MRP

(viii) Legal people

(ix) MRP (Appeals) personnel

(x) Registrar MRP

(xi) Chief Appeals Officer

3.8 Any other suggestions for future programs?

- (i) Have more consultation (options) for time of meeting
- (ii) Registrar to analyze common deficiencies in MRP Reports and report to next meeting.
- (iii) Review of results of Implementation
- (iv) Generic problems inherent to Chairmen
- (v) Germaine subjects
- (vi) Much the same format
- (vii) Quarterly meetings
- (viii) More round table discussions on main issues.

Yours sincerely,

DR. LEONARD C. JENKINS, M.D.
Registrar, Medical Review
Panels

appraisal\LCJ\stb

# APPENDIX 16

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# SECTION 6

# FIGURES AND TABLES

Figure 1

**Schematic Organizational Chart of the Medical Review Panel Department**

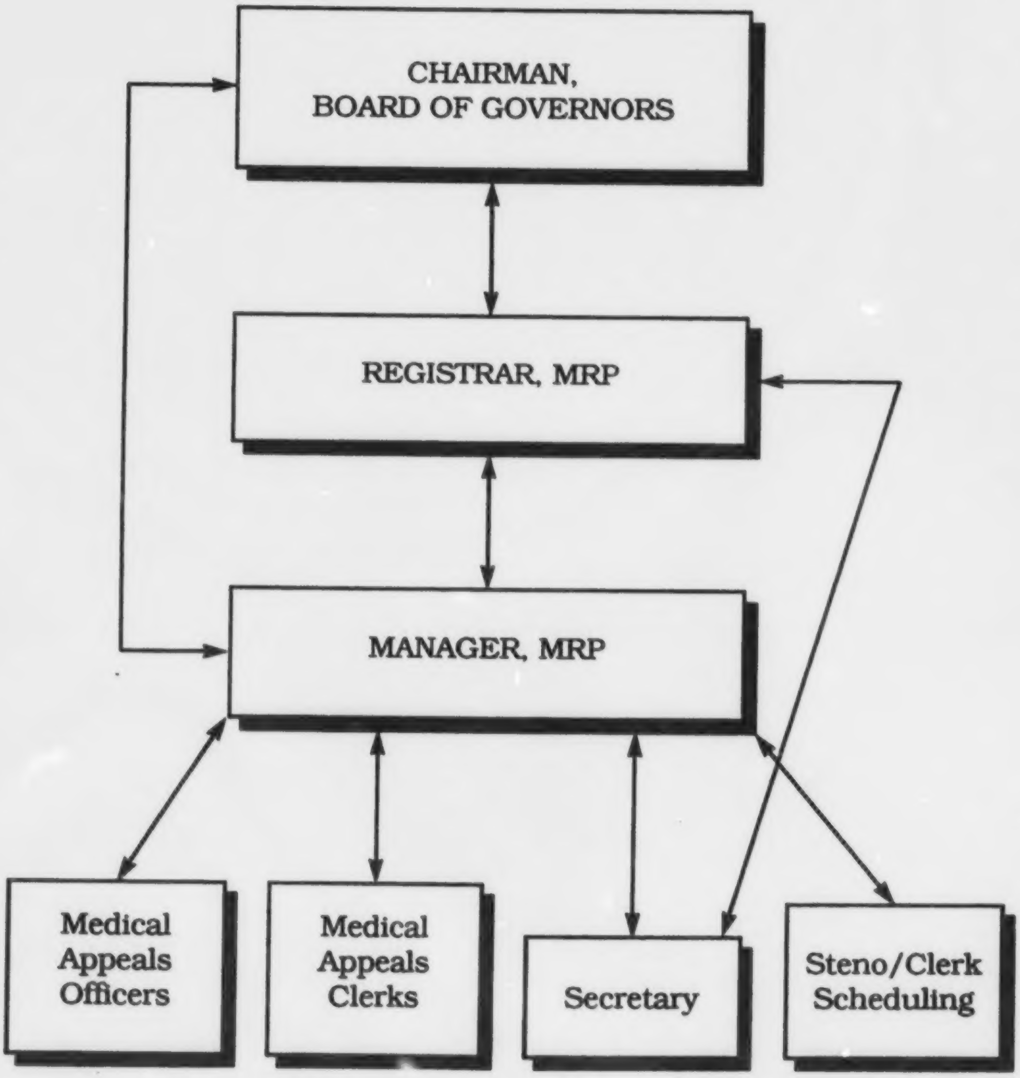

CHAIRMAN, BOARD OF GOVERNORS
REGISTRAR, MRP
MANAGER, MRP
Medical Appeals Officers
Medical Appeals Clerks
Secretary
Steno/Clerk Scheduling

Figure 2

## Access Routes to the Medical Review Panel Appeal Process Sections 58(3)(4), 63(1)

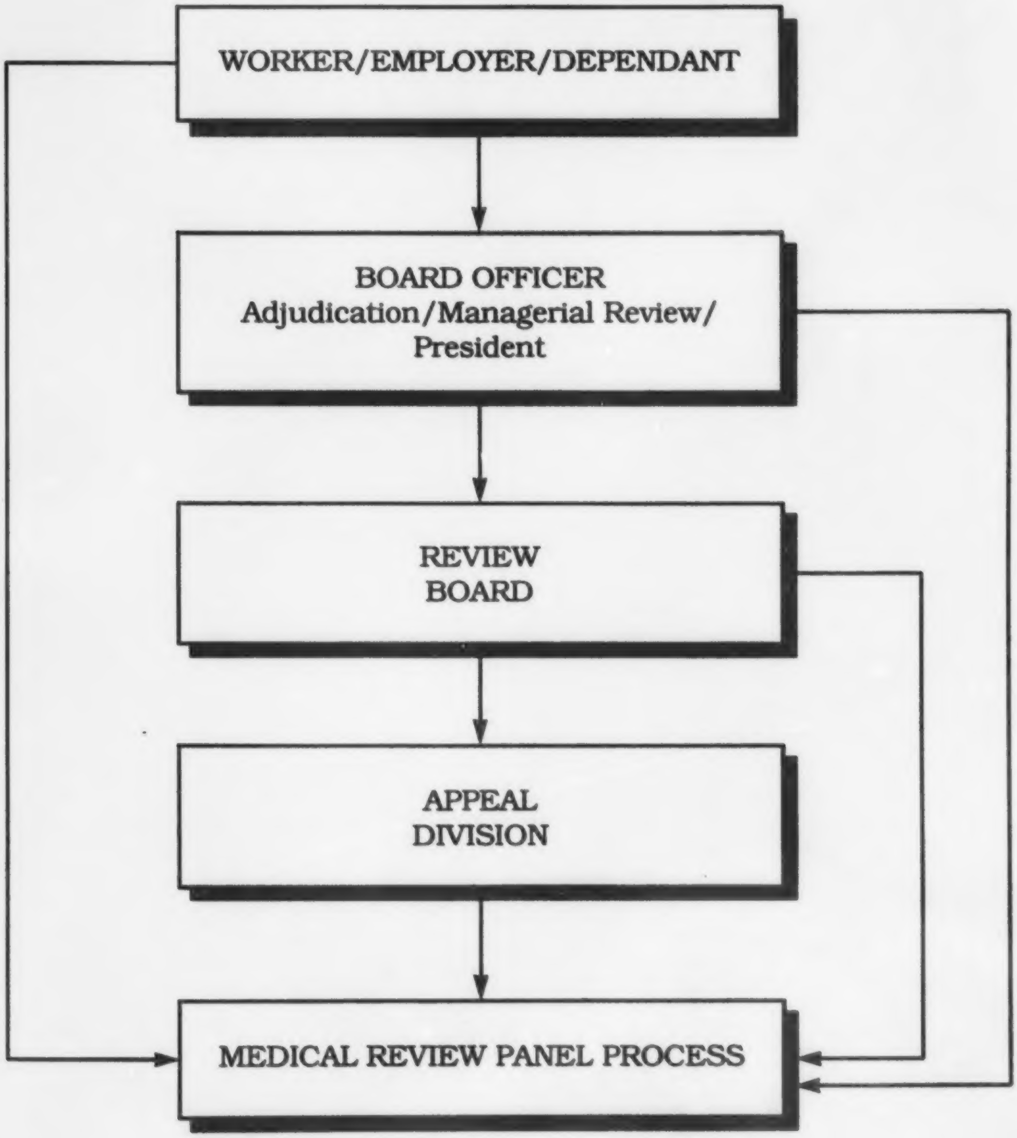
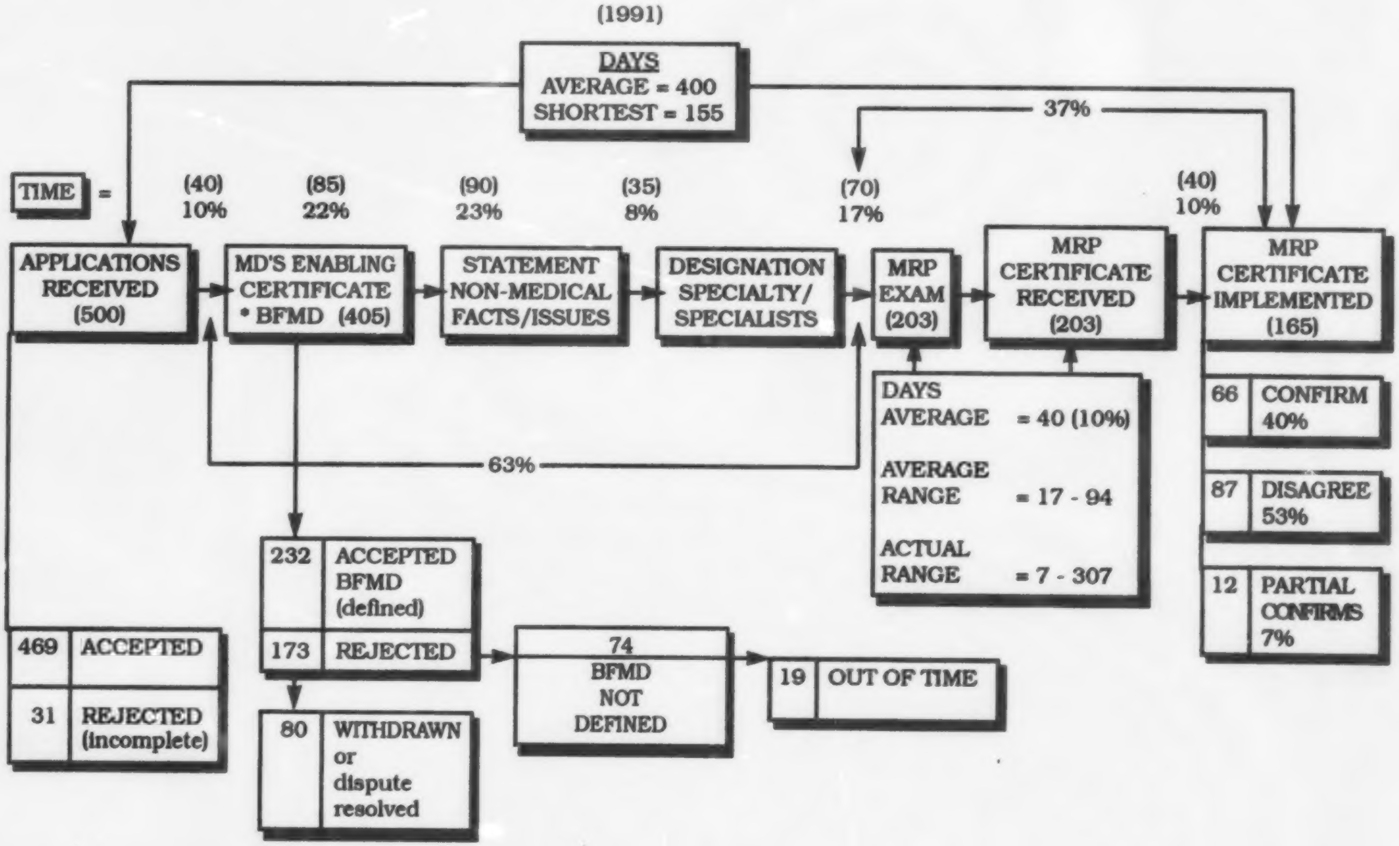

WORKER/EMPLOYER/DEPENDANT
BOARD OFFICER
Adjudication/Managerial Review/
President
REVIEW
BOARD
APPEAL
DIVISION
MEDICAL REVIEW PANEL PROCESS

Figure 3

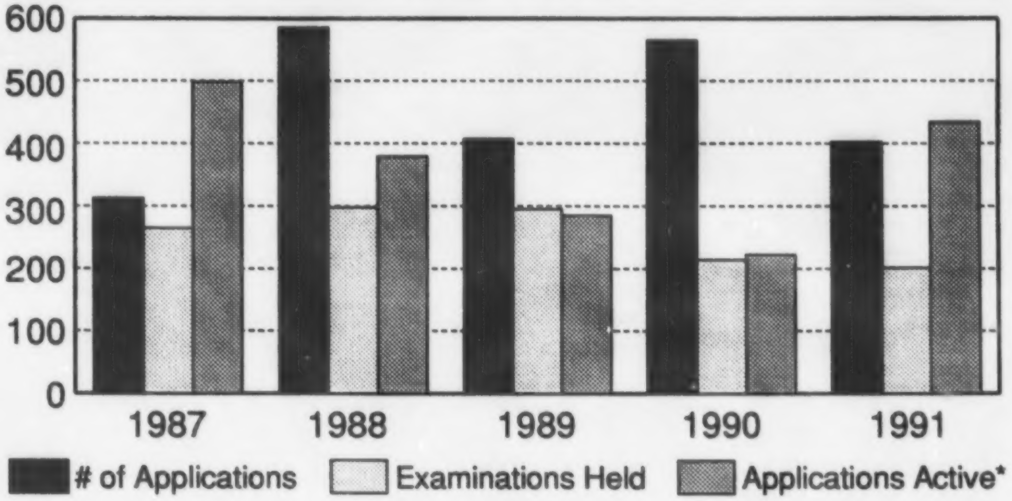
## Medical Review Panels: Volume and Time Flows


(1991)
DAYS
AVERAGE = 400
SHORTEST = 155
37%
TIME =
(40)
10%
(85)
22%
(90)
23%
(35)
8%
(70)
17%
(40)
10%
APPLICATIONS RECEIVED (500)
MD'S ENABLING CERTIFICATE * BFMD (405)
STATEMENT NON-MEDICAL FACTS/ISSUES
DESIGNATION SPECIALTY/ SPECIALISTS
MRP EXAM (203)
MRP CERTIFICATE RECEIVED (203)
MRP CERTIFICATE IMPLEMENTED (165)
66 CONFIRM 40%
87 DISAGREE 53%
12 PARTIAL CONFIRMS 7%
DAYS
AVERAGE = 40 (10%)
AVERAGE RANGE = 17 - 94
ACTUAL RANGE = 7 - 307
63%
232 ACCEPTED BFMD (defined)
173 REJECTED
80 WITHDRAWN or dispute resolved
74 BFMD NOT DEFINED
19 OUT OF TIME
469 ACCEPTED
31 REJECTED (incomplete)

* BONA FIDE MEDICAL DISPUTE

Figure 4

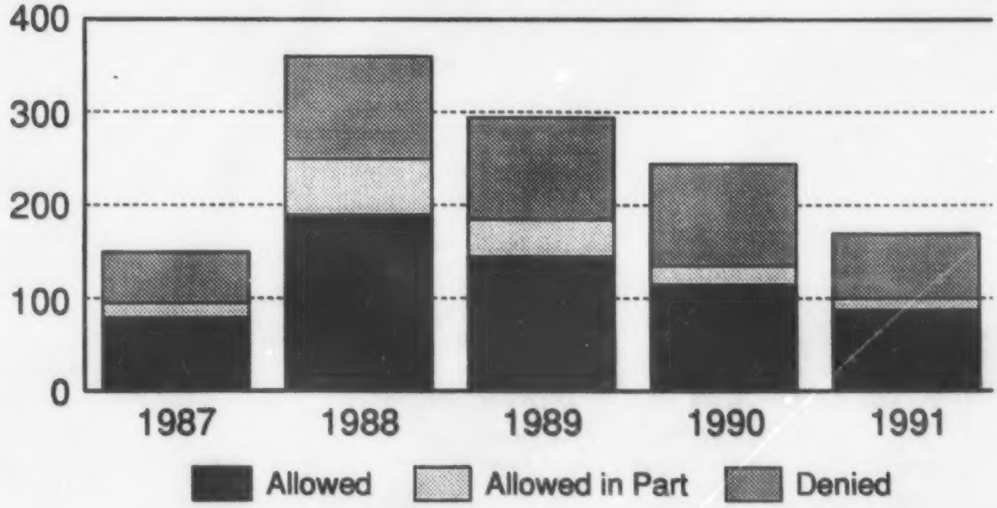
**Medical Review Panel Statistics**
Volume Profile



* Number of applications active at year end.

Figure 5

**Medical Review Panel Statistics**
Outcomes of Appeal



(Figures Courtesy of Compensation Services Division)

Table 1

## Medical Review Panel (MPR) Department

| NAME | POSITION | LOCAL |
|---|---|---|
| JENKINS, Dr. Leonard C. | Registrar | 7503 |
| OLSON, Judy | Manager | 6713 |
| BRETT, Diana | Medical Appeals Officer | 6719 |
| HARWOOD, Bev | Medical Appeals Officer | 6728 |
| HUGHES, Gwenda | Medical Appeals Officer | 6731 |
| NEWMAN, Kris | Medical Appeals Officer | 6718 |
| CHARRON, Barbara | Medical Appeals Clerk | 6721 |
| DICKSON, Lisa | Medical Appeals Clerk | 6222 |
| MYKYTIW, Faye | Medical Appeals Clerk | 6724 |
| UKRANITZ, Helen | Medical Appeals Clerk | 6736 |
| McCULLOUGH, Francine | Panel Scheduling Steno/Clerk | 6703 |
| **RESOURCE SUPPORT** | | |
| GREENE, Heather | Legal Advisor, to the Chairman, Board of Governors | 6517 |
| BOGYO, Terry | Executive Assistant, to the Chairman, Board of Governors | 3202 |
| CHAPMAN, Wilma | Administrative Assistant to the Chairman | 7548 |
| te BOEKHORST, Sylvia | Secretary | 7594 |
| HII, Helen | Secretary | 7594 |
| **MEDICAL REVIEW PANEL DEPARTMENT** | | 276-3122 |
| **FAX - MEDICAL REVIEW PANELS** | | 279-7693 |

Table 2

## Source Patterns For New Medical Review Panels Applications
### (For 12 - Month Period June 1, 1991 - May 31, 1992)

| DECISION MAKER | NUMBERS | | PERCENT (%) | |
|---|---|---|---|---|
| Appeal Division - Decision | 303 | 344 | 48.6 | 55.2 |
| Referral | 41 | | 6.6 | |
| Board Officer | 132 | | 21.2 | |
| Review Board | 85 | | 13.6 | |
| Bill 15 (Decision 3) | 62 | | 10 | |
| **TOTALS** | **623** | | **100** | |

Table 3

## Five-Year Trends in Applications

| YEAR | APPLICATIONS RECEIVED | APPLICATIONS CONSIDERED | | | | APPLICATIONS ACTIVE AT YEAR END |
|---|---|---|---|---|---|---|
| | | Accepted (BFMD) Defined | Rejected BFMD Not Defined | Out Of Time | Withdrawn or Dispute Resolved | |
| 1987 | 398 | 240 | 65 | 4 | 12 | 501 |
| 1988 | 433 | 316 | 110 | 31 | 124 | 373 |
| 1989 | 369 | 190 | 98 | 26 | 101 | 276 |
| 1990 | 397 | 221 | 129 | 23 | 81 | 234 |
| 1991 | 500 | 232 | 74 | 19 | 80 | 442 |
| **TOTAL** | **2,097** | **1,199** | **476** | **103** | **398** | |

Table 4

## MRP Applications Awaiting Consideration* and Being Processed

| STATUS | NUMBERS | PERCENT |
|---|---|---|
| Incomplete<br>[Awaiting form(s) or file(s)] | 83 | 10 |
| Awaiting consideration by MAO ♦ | 276 | 65 |
| Applications being processed | 126 | 25 |
| **TOTALS** | **485** | **100** |

* As of June 30, 1992

♦ MAO = Medical Appeals Officer

Table 5

## Medical Review Panel Department Statistics

## Average Number of Days For Completion of Appeals

| YEAR | AVERAGE # DAYS TO COMPLETION | (=MONTHS) |
|---|---|---|
| 1985 | 884 (Shortest 557) | 29.0 |
| 1986 | 604 (Shortest 261) | 20.0 |
| 1987 | 464 (Shortest 177) | 15.0 |
| 1988 | 434 (Shortest 167) | 14.2 |
| 1989 | 319 (Shortest 145) | 10.4 |
| 1990 | 242 (Shortest 126) | 7.9 |
| 1991 | 400 (Shortest 155) | 13.1 |

Table 6

## Composition of Joint Medical Committee
## (1992)

| POSITION | NAME |
|---|---|
| Executive Director, BCMA | Dr. Norman Finlayson |
| Registrar, College of Physicians and Surgeons of B.C. | Dr. T. F. Handley |
| Assistant Executive Director, BCMA | Dr. Clive Thompson |

Table 7

## Specialties Available for Medical Review Panels

Anaesthesia
Cardiology
Cardiovascular and Thoracic Surgery
Dermatology
General Practice
General Surgery
Gynaecology
Immunology/Allergy
Internal Medicine
Nephrology
Neurology
Neurosurgery
Pathology
Physical Medicine
Ophthalmology
Orthopaedic Surgery
Otolaryngology
Plastic Surgery
Psychiatry
Radiology
Respirology
Rheumatology
Urology
Vascular Surgery

Table 8.1

## Frequency of Specialties Used in Medical Review Panels 1991

| SPECIALTY | NUMBERS | % |
|---|---|---|
| Orthopaedic Surgery | 149 | 73.0 |
| Neurology | 19 | 9.0 |
| Neurosurgery | 3 | 1.5 |
| Neurology and Neurosurgery | 4 | 2.0 |
| Dermatology | 1 | 0.5 |
| Respiratory Disease | 5 | 2.5 |
| Psychiatry | 9 | 5.0 |
| Psychiatry and Neurosurgery | 1 | 0.5 |
| Otolaryngology | 3 | 1.5 |
| Rheumatology | 1 | 0.5 |
| General Surgery | 4 | 2.0 |
| Internal Medicine | 3 | 1.5 |
| Physical Medicine | 1 | 0.5 |
| **TOTALS** | **203** | **100%** |

Table 8.2

## Frequency of Specialties Used in Medical Review Panels
## 1992*

| SPECIALTY | NUMBERS | % |
|---|---|---|
| Orthopaedic Surgery | 73 | 73 |
| Neurology | 11 | 11 |
| Neurology and Neurosurgery | 2 | 2 |
| Respiratory Disease | 4 | 4 |
| Internal Medicine | 3 | 3 |
| Plastic Surgery | 3 | 3 |
| Psychiatry | 2 | 2 |
| Cardiology | 1 | 1 |
| Otolaryngology | 1 | 1 |
| **TOTALS** | **100** | **100%** |

* From January 1 to June 30, 1992

Table 9

## Current MRP Chairmen and Dates of Appointment

| NAME | DATE OF APPOINTMENT |
|---|---|
| Dr. Nigel H. CLARK | January 30, 1975 |
| DR. S. L. SUNSHINE | January 30, 1975 |
| Dr. Victor DIRNFELD | July 13, 1978 |
| Dr. Peter J. BANKS | April 25, 1986 |
| Dr. Darryl G. MORRIS | April 25, 1986 |
| Dr. Geoffrey L. NANSON | April 25, 1986 |
| Dr. J. T. SANDY | April 25, 1986 |
| Dr. R. Cameron HARRISON | April 25, 1986 |
| Dr. Peter ALLEN | March 1, 1990 |
| Dr. Ian CONNELL | March 1, 1990 |
| Dr. Beverly BARRON | March 1, 1990 |
| Dr. R. PURKIS | March 1, 1990 |
| Dr. John SLOAN | March 1, 1990 |
| Dr. John SMITH | March 1, 1990 |

Table 10

## Disqualifying Factors For a Specialist or a Chairman on a Medical Review Panel

1.0 Examines workers on behalf of the employer
2.0 Has treated the worker
3.0 Has acted as a Consultant in the treatment of the worker
4.0 Is a partner of, or practices medicine together with Specialist
5.0 Related
6.0 Possible perception of bias on any other ground

Table 11

## MRP Chairmen Activities: Times Between Date of Panel and Date of Panel Certificate Received (1991)

| CHAIRMAN (CODED) | # OF PANELS | TOTAL DAYS | FASTEST PANEL | SLOWEST PANEL | AVERAGE TIME |
|---|---|---|---|---|---|
| A | 19 | 337 | 8 | 33 | 18 |
| B | 10 | 208 | 12 | 33 | 21 |
| C | 16 | 350 | 7 | 44 | 22 |
| D | 9 | 200 | 14 | 29 | 22 |
| E | 19 | 429 | 11 | 56 | 23 |
| F | 12 | 314 | 12 | 105 | 26 |
| G | 10 | 263 | 14 | 58 | 26 |
| H | 15 | 409 | 13 | 41 | 27 |
| I | 18 | 605 | 20 | 90 | 34 |
| J | 17 | 603 | 20 | 58 | 35 |
| K | 15 | 587 | 20 | 116 | 39 |
| L | 8 | 577 | 17 | 307 | 72 |
| M | 5 | 371 | 21 | 188 | 74 |
| N | 16 | 1201 | 23 | 117 | 75 |
| O | 14 | 1125 | 39 | 140 | 80 |
| **TOTALS** | **203** | **7,479** | | | |
| **AVERAGES (AVG. VARIATIONS)** | **14** | **498** | **(17)** | **(94)** | **40** |
| **ACTUAL VARIATIONS** | **(5 - 19)** | **(200-1201)** | **(7-39)** | **(29-307)** | **(18-80)** |

Table 12

## MRP: Five-Year Trends in Panel Certificates

| YEAR | PANEL EXAM | CERTIFICATES RECEIVED | CERTIFICATES IMPLEMENTED | DECISIONS | | |
|---|---|---|---|---|---|---|
| | | | | CONFIRM | DISAGREE | PARTIAL DISAGREE |
| 1987 | 254 | 211 | 148 | 58 | 73 | 17 |
| 1988 | 299 | 314 | 358 | 131 | 181 | 45 |
| 1989 | 297 | 290 | 291 | 114 | 143 | 34 |
| 1990 | 222 | 231 | 250 | 110 | 117 | 23 |
| 1991 | 203 | 203 | 165 | 66 (41)* | 87 (52)* | 12 (7)* |
| **TOTALS** | **1275** | **1249** | **1212** | **479 (39)*** | **602 (51)*** | **131 (10)*** |

* (Percent %)

Table 13

## Outcomes: Medical Review Panels: Five-Year Trends

| NEW APPLICATIONS | | APPLICATIONS CONSIDERED | | | | DECISIONS | | |
|---|---|---|---|---|---|---|---|---|
| YEAR | NUMBERS | BFMD ACCEPTED (DEFINED) | BFMD REJECTED (NOT DEFINED) | OUT OF TIME | WITHDRAWN or DISPUTE RESOLVED | UPHOLDS WCB | DISAGREES WITH WCB | PARTIALLY UPHOLDS |
| 1987 | 398 | 240 | 65 | 4 | 12 | 58 | 73 | 17 |
| 1988 | 433 | 316 | 110 | 31 | 124 | 131 | 182 | 45 |
| 1989 | 369 | 190 | 98 | 26 | 101 | 114 | 143 | 34 |
| 1990 | 397 | 221 | 129 | 23 | 81 | 110 | 117 | 23 |
| 1991 | 500 | 232 | 74 | 19 | 80 | 66 (41)* | 87 (52)* | 12(7)* |
| **TOTALS** | **2,097** | **1,199** | **476** | **103** | **398** | **479 (39)*** | **602 (51)*** | **131 (10)*** |

* (% Percent)

Table 14

## Chairmen, MRP Decisions: Five-Year Trends

| Chairman (Code) | Certificates Received 1987 to Feb.1992 | Does Not Confirm Board Decision | Confirms Board Decision | Partial Confirms Board Decision | % of Total Panels Which Did Not Confirm Board Decision |
|---|---|---|---|---|---|
| M | 10 | 3 | 7 | 0 | 30.00% |
| P | 9 | 3 | 5 | 1 | 33.33% |
| O | 114 | 39 | 61 | 14 | 34.21% |
| G | 46 | 18 | 22 | 6 | 39.13% |
| L | 138 | 57 | 64 | 17 | 41.30% |
| E | 108 | 45 | 53 | 10 | 41.67% |
| F | 122 | 56 | 50 | 16 | 45.90% |
| K | 23 | 11 | 10 | 2 | 47.83% |
| C | 22 | 11 | 9 | 2 | 50.00% |
| Q | 89 | 47 | 35 | 7 | 52.81% |
| H | 95 | 52 | 30 | 13 | 54.74% |
| I | 111 | 61 | 35 | 15 | 54.95% |
| A | 95 | 53 | 32 | 10 | 55.79% |
| J | 123 | 70 | 41 | 12 | 56.91% |
| N | 99 | 60 | 29 | 10 | 60.61% |
| D | 12 | 9 | 3 | 0 | 75.00% |
| B | 13 | 10 | 3 | 0 | 76.92% |
| **TOTALS** | **1,229** | **605** | **489** | **135** | **50.06%** |

Table 15

## 1992 Estimated (Projected) Costs per MRP Panel

| OPERATIONAL BUDGET PANEL | | TOTALS | COST PER |
|---|---|---|---|
| * **MRP DEPARTMENT** | | $585,250 | $2,883 |
| Salaries/Payroll | $518,000 | | |
| Supplies & Stationery | 3,800 | | |
| Communications | 1,350 | | |
| Equipment | 50,000 | | |
| Publications & Advertising | 10,000 | | |
| Other | 2,100 | | |
| ♦ Medical Aid | | $461,337 | $2,272 |
| **TOTAL** | | **$1,046,587** | |
| **APPLICATIONS RECEIVED** | | **500** | **$2,093** |
| **MRP Held (Implemented)** | | **203** | **$5,145** |

* 1992 - Projected on basis of January 1 - May 31, 1992

♦ 1991 - Medical Aid component = Chairmen and Specialist Members MRP